STATE TITLE V BLOCK GRANT NARRATIVE
STATE: KY
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

Assurances and Certifications for the Title V, Maternal and Child Health Block Grant are on file in the office of the Division of Adult and Child Health Improvement. 502-564-4830.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

Public input during the Title V Block Grant development process is accomplished in several ways.

In April, the Department for Public Health submits an annual report to the Legislative Research Commission of the Kentucky General Assembly.

A public hearing is scheduled annually, during July, prior to submission of the application. Information about the Title V Application process, overview of the purpose and data compared over multiple years is mailed to approximately 125 interested parties. These include local health departments, parent organizations and other advocates. A news release is sent to major media within the state announcing the public hearing. The FY 06 public hearing was held on July 8, 2005. There were no comments.

Parents are well represented on the Inter-agency Coordinating Council for First Steps.

The Commission assures family and consumer in-put to program development by including two parent representatives and one young adult patient representative on the seven-member Board of Commissioners. Families and patients are also represented on the Commission's Hemophilia Advisory Committee and on a volunteer advisory committee for the Universal Newborn Hearing Screening program. All these groups receive regular program updates and have the opportunity to provide consultation and work with the Commission on various committees or workgroups throughout the year. Information about the Block Grant performance measures is shared with these advisory groups.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

Overview

Geographic

Kentucky is a state with diverse topography including fertile fields in the Central and West used to support agriculture, the Appalachian Mountain Range (East) supporting lumber and coal industries, the Bluegrass (Central) which is world renowned for its thoroughbred horse industry and major waterways, such as the Ohio and Kentucky Rivers. Louisville is Kentucky's largest city and Lexington is second in population. Both cities have major universities, the University of Louisville and the University of Kentucky, with research and teaching facilities that support public health throughout the state. Other universities also support public health including Kentucky State University (Frankfort), Eastern Kentucky University (Richmond) and Western Kentucky University (Bowling Green), among others.

Several major interstates and Kentucky Parkways run throughout Kentucky. North/South routes include I-65 and I-75; East/West Routes include I-64 and I-24. While these major thoroughfares serve much of the state population, key areas still remain isolated and distant from major cities, universities and services. The Eastern Kentucky Coal Field is the primary region falling into this category. Due to the mountainous areas with winding and narrow roads, residents may drive for several hours to reach a main interstate artery. Many of these areas have a shortage of health care professionals and rely heavily upon local health department and regional hospitals for services.

Kentucky has 120 counties. These vary from the small Eastern Kentucky county of Robertson (pop. 2,266 in 2000) to Jefferson County (pop. 693,604 in 2000). Because of the small populations in many counties, county-specific health data is difficult to obtain and may have questionable accuracy when available. This means that regional data is often the only information available to health professionals planning interventions and assessing need.

Demographic

Kentucky's total population is 4,041,769 according to 2000 Census figures. During the past decade, Kentucky's population grew by 356,473 persons, a growth rate of 9.7 %. This places Kentucky 25th among states in population. During the previous decade, Kentucky's population grew by only 7 %. Kentucky's rate of live births has also steadily increased; from 52,054 in 1995 to 55,147 in 2003; an increase of 6%.

Kentucky continues to experience inequities between the infant mortality rate for black and white infants, although the black infant mortality rate is slowly decreasing (from a high of 15.4 in 1998 to a provisional level of 11.6 in 2003). Only 8.8 % of the total births in 2003 were classified as black. In the Louisville/Jefferson County area, Kentucky's largest urban area, the African-American population comprised 18.9 % of the total county population (for a total of 130,928 citizens) in 2000, yet this accounted for 44 % of the entire African-American population in the Commonwealth of Kentucky. Other counties with substantial African-American populations (as a portion of the total population in the state) in 2000 include Fayette (12%), Christian (6%), Hardin (4%) and Warren (2.7%).

2000 Census data also shows that the Hispanic population in Kentucky is growing rapidly, with an increase of 172.6 % over 1990 Census totals. The Hispanic population nearly tripled from 20,363 in 1990 to 59,939 in 2000. This figure, of course, does not take the illegal population into account, which is thought to be a substantial number. This data reports counties with the largest Hispanic population are also Jefferson (12,370), Fayette (8,561), Hardin (11,178), Christian (3,494), and Warren (2,466).

Patient data for children enrolled in the Commission for Children with Special Health Care Needs reflects the growing Hispanic population and comparatively low numbers of other immigrant

populations. A data snapshot of the Commission's population taken on June 30, 2005 showed the following distributions among the 7,255 active enrollees, 82% white; 8.2% Black/African American; 3.5% Hispanic; 2.2% Other; less than 1% Asian, less than 1% Native American/Alaska native and less than 1% Native Hawaiian/Pacific Islander. Of these same 7,255 active enrollees 6,962 listed English as their preferred language and 184 individuals listed Spanish as the next highest preferred language. Sign language continues to rank third, Bosnian 4th. Other language preferences include Albanian, Arabic, German, Russian, Somolian, Vietnamese, etc.

Socioeconomic Indicators

Socioeconomic indicators for Kentucky's population vary widely. A few of the key indicators are reviewed below for Kentucky. Data is supplied by 2000 County Health Profiles, produced by the Kentucky State Center for Health Statistics, Kentucky Department for Public Health.

Rates of Medicaid Eligibility and Use: In 2000, 14.9 % of the population of Kentucky was Medicaid eligible. Owsley County ranked highest in Medicaid eligible percent (50.6%) and Oldham County ranked lowest (3.7%). Statewide, of the 14.9 % eligible for Medicaid, only 14.4% of those individuals actually used Medicaid services. Medicaid Utilization ranges from a high in Owsley County (49.5%) to a low in Oldham County (3.6%).

Food Stamp, AFDC, and WIC Recipients: These measures present data on the proportions of the population who accessed programs for the indigent. In fiscal year 2000, 10.0% of the total population received food stamps, 3.4% received AFDC benefits, and 8.8% of the eligible population was served by the WIC program. Owsley County ranked highest in food stamp percent (40.7%), Wolfe County, highest in WIC percent (20.3%), and Owsley County, highest in AFDC percent (14.6%).

Median Household Income: In 1999, the most recent available at the time of this publication, the median household income for Kentucky was $33,732.

Persons in Poverty: Based on 1999 statistics, the most recent available, 15.8% of the population in Kentucky were below the poverty level, a decrease from 17.9% in 1995. Kentucky counties ranged from 33.7% in Owsley County to 5.0% in Oldham County. It is estimated that one-fifth (20.2%) of the total population under the age of 18 lived in poverty in 1999, a marked decrease from 26.0% in 1995. Wolfe County was the highest in this measure at 44.8%.

Unemployment Rate: The unemployment rate in December of 2002 was 5.4 %, an increase over the previous year. This ranged from a high in Taylor County of 15.5% as a result of the closing of the Fruit of the Loom plant several years ago to a low in Jessamine County of 1.5% (an affluent suburb to the south of Fayette County).

Educational Status: The educational status of both men and women is closely related to socioeconomic status and also has implications for health, as women are key to the provision of health care in most families. In 2000, the educational status of mothers remained steady with one in five (21.4%) of Kentucky women with less than 12 years of education. This measure ranged from 43.7% in Clay County to 6.9% in Oldham County.

Access to Primary Care

Access issues are still a problem for many families due to poverty, transportation issues and cultural isolation. Of the 120 counties in Kentucky, most of the Health Professional Shortage Areas (HPSA's) are based on the county as the service area.

In 2004, there are 41 Geographic HPSAs and 33 low-income HPSAs in Kentucky. There are also 15 dental HPSA designations and 96 counties identified as Mental Health HPSAs.

Discussion about Kentucky's KCHIP and KenPAC programs (Medicaid Managed Care), as well as

federally funded primary care centers, which improve access to care within our state, is included later within the narrative (Section III-E, State Agency Coordination).

Cabinet for Health and Family Services -- Provision of Health in Kentucky

Upon taking the oath of office in December 2003, Governor Ernie Fletcher announced the reorganization of Kentucky state government. The Cabinet for Health Services and the Cabinet for Families and Children were consolidated into a single cabinet called The Cabinet for Health and Family Services. The Cabinet is divided into four administrative units each lead by an undersecretary. The four units are: Administrative and Fiscal Affairs; Health Services; Human Services; and Children and Family Services.

The Division of Adult and Child Health Improvement within the Department for Public Health reports to the Undersecretary for Health. The Commission for Children with Special Health Care Needs reports to the Undersecretary for Children and Family Services.

More about the Cabinet for Health and Family Services is included within Section IIIC - Organizational Structure.

Department for Public Health - Mission

As mandated under KRS 211.005 the definition of core public health was specified at the beginning of the chapter on public health laws. This statute mandates that the Department for Public Health develop and operate all programs for assessing the health status of the population, for the promotion of health and for the prevention of disease, injury, disability, and premature death. Services provided by the Department for Public Health and all local health departments include: enforcement of public health regulations, surveillance of public health, communicable disease control, public health education, implementation of public health policy, efforts directed to population risk reduction, and disaster preparedness. This identification by statute fosters the development of the role of the Title V agency to provide a comprehensive approach to health. The Department for Public Health, in conjunction with the Title V program, provides preventive clinical services in circumstances where providers are not available.

Prior to 1998, the Department for Public Health brought together the stakeholders within the public health community to develop a vision, mission and core values around the role of public health. Included in the ensuing discussion was an emphasis on the core functions of public health; assessment, assurance and policy development. Emerging from these efforts a Public Health Improvement Plan was developed for Kentucky, which is still currently in use. The planning efforts which were published in 1998 identified the following priorities:

-Teenage pregnancy and low birth weight babies
-Infant death
-Deaths due to heart disease, cancer, and stroke
-Health issues related to a rapidly growing elderly population
-Immunizations for children
-Disability and premature death of children and youth
-Lifestyle activities, including physical fitness and exercise, nutrition, sexual practices, use of tobacco, alcohol, and illegal substances, and seat belt use
-Prenatal care for pregnant women
-Access by both private and public health providers to health and health-related information
-Environmental health standards
-Food safety
-Communicable diseases

Within the same timeframe, the state developed comprehensive, integrated strategies for improvement of economic opportunity and a standard of living above the national average. Five

distinct strategies were designed:

-Promoting economic development
-Improving education product
-Building self-sustaining families
-Strengthening efficiency and operations of government
-Reducing crime and its cost to society

The Department for Public Health had a role in all of these strategic initiatives, but the efforts identified within the building of self-sustaining families affect the maternal and child health population most significantly.

Kentucky's Public Health Challenges in Maternal and Child Health

Low birth weight and prematurity continue to be a challenge for Kentucky's mothers and infants. Provisional data from Kentucky Vital Statistics, Live Birth Certificate Files show that in 2003, 8.5 % of Kentucky's infants are born weighing less than 2,500 grams and 1.7 % were born weighing less then 1,500 grams (very low birth weight). Preterm births (defined as live births at less than 38 weeks gestation) have risen from 10.2 % in 1998 to 11.9 % in 2003. The percentage of preterm births by race also varies significantly. In 2003, 15.2% of black infants were born prematurely as opposed to approximately 11.6% of all white births.

Smoking during pregnancy, sexually transmitted and oral infections as well as late or no prenatal care are just a few of the known risk factors which impact these health indicators. While birth certificate data reports that the number of women who smoked during pregnancy has been steadily declining (from 27% in 1991 to 23.4% in 2003), this data is self-reported and is therefore suspect. Additional information about smoking may be available when the new live birth certificate becomes official, in 2004. (Question 37 on the new live birth certificate asks not just generally whether a woman smokes or not but how many cigarettes she smoked before, during and after pregnancy, by trimester. Data will still be self-reported.) Discussion about many of the risk factors associated with prematurity and low birthweight and the programs that address them will be discussed within various performance measures later within this narrative.

Where is Kentucky going in the fight against prematurity and low birth weight? Several major initiatives have begun to address this significant health problem.

Through a long-established relationship with the Greater Kentucky Chapter of the March of Dimes Birth Defects Foundation, public and private health professionals are learning more about the causes and health outcomes of low birth weight and prematurity. The 2002 Maternal and Child Health Conference, reaching more than 700 health professionals throughout the state, focused on prematurity; inviting Dr. Jennifer Howse, President of the March of Dimes National Foundation as the Keynote Speaker. Dr. Howse called health professionals to action and unveiled the national March of Dimes Prematurity Campaign effort. Throughout the next one and one half days, many breakout sessions discussed specific aspects of prematurity; from the suspected link to oral health infections to racial and ethnic disparities in preterm delivery. The closing plenary speakers included Dr. Henrietta Bada, M.D., M.P.H. (the long-term impact of public health on prematurity and low birth weight) and Magda Peck, Sc.D., Chief and Executive Director of CityMatCH, who taught participants how to build effective partnerships to assure change.

The fight against prematurity continues with another example of a cooperative effort to jointly addressing this issue. The Kentucky Perinatal Association 2005 Annual meeting presentation of "Summit on Prematurity 2005", June 5-7, 2005 at Lake Cumberland State Resort Park.

This conference is traditionally attended by those working in the field of perinatology and is an excellent opportunity to reach physicians and neonatal nurses from across the state. Topics included within the Summit agenda include "Newborn Metabolic Screening for KY 2005" by Joe Hersh, MD;

"Domestic Violence and Substance Abuse" and "Update on Prematurity Research and National March of Dimes" by Karla Damus, MSPH, PhD, RN; "Maternal Perinatal Nutrition" by Diane Sprowl, RD; "In-vitro Fertilization and Advanced Reprofuctive Technologies" by Jon Cohen, MD; "Perinatal Loss" by Jeannette Osbourne, RN; and "Smoking Environment: How Far to Go?" by Kim Yolton, PhD.

What is the next step for Kentucky as it addresses the issue of prematurity? The Department for Public Health will continue to participate with the March of Dimes as a primary member of the Prematurity Campaign Committee. Kentucky's Early Childhood Initiative KIDS NOW will continue to support programs (such as HANDS Voluntary Home Visitation) which impacts prematurity and low birth weight.

The Department for Public Health is developing an Infant Mortality program that will address the racial disparity in the infant mortality rate in the Commonwealth. The program will pilot in three Louisville Metro communities, with some of the highest infant mortality rates in KY. The three neighborhoods, Bridges of Hope, Northwest and Ujima, are communities that have also been awarded a $1,275,00 Healthy Start, Eliminating Disparities in Perinatal Health program grant, based on the high infant mortality rate in those areas as well as other factors. The data for 2002 indicates the following: the infant mortality rate for the USA is 7/1000 live births, 7.2 for Kentucky and 8.9 for the Louisville Metro area. The infant mortality rate for the white population of the Louisville Metro area is 6.8 and for the African American population it is 15. The infant mortality rates for the three targeted Healthy Start communities, which are mostly African American, is Bridges of Hope is 12.5, Northwest is 15.4 and Ujima is 24.2.

The program will address the infant mortality problem by working closely with other state programs to educate young women of child bearing age who are pregnant or may become pregnant. These programs include the Family Planning program, KY Birth Surveillance Registry, the Prenatal Program, the Tobacco Program and the Substance Abuse Counselors for the KIDS NOW Initiative.

An initial meeting for the program was held in May 2005 in Louisville and was attended by representatives of the above state programs and local agencies that will help address this issue and the state legislators that represent the three pilot communities. Infant mortality data and information was provided. The group will meet again to determine next steps.

Congenital anomalies remain the leading cause of infant mortality in Kentucky. In 2003, the rate of infant deaths due to congenital anomalies was 13.0/10,000.

Kentucky has unique characteristics that may lead to an increased prevalence of certain birth defects such as neural tube defects and diabetic embryopathy. The eastern portion of Kentucky is along the Appalachian foothills. For years, individuals in this part of the state were isolated geographically and culturally. Dr. Bryan D. Hall, Dysmorphologist, retired from the University of Kentucky, estimates that the rate of consanguinity in this population, for which he provides clinical genetic services, to be approximately 7%. While this is biased as it is drawn from individuals seeking genetic evaluations or counseling, it is still greatly in excess of the national rates of consanguinity that are estimated to be approximately 0.5 %. The high rate of consanguinity may result in increased numbers of children with autosomal recessive conditions as well as multifactorial birth defects.

Kentucky is addressing this problem with the support of the Kentucky Birth Surveillance Registry (KBSR). KBSR identifies children with birth defects and disabling conditions from birth to five years of age through a combination of active and passive surveillance. This information is utilized to estimate the prevalence of specific birth defects and to geographically map the information for identification of potential clusters of birth defects. Children identified in KBSR may also be referred to appropriate services such as Kentucky's Early Intervention System, First Steps. Data resulting from this surveillance system will enable program staff to target intervention efforts to areas of the state most in need and should result in lower rates for all six national outcomes measures. KBSR participates in educational efforts to promote preconception health promotion to reduce the occurrence of birth defects.

Significant work has taken place over the past few years within KBSR. KBSR had funding from the Centers for Disease Control and Prevention (CDC) through 2005 to improve the surveillance system and referral component. Additionally, the KBSR system recently received a "B" from a national review of all birth surveillance systems in the nation. Very few systems received such a high grade, particularly for those that have only been in existence for a few years.

Staff for the KBSR successfully developed an integrated data system, which links Vital Records (live births, stillbirths and death certificates) with UB-92 hospital discharge data, to gain a complete record on each child reported to have a congenital anomaly. Many agencies report to the Registry, including the Spina Bifida Association and the Commission for Children with Special Health Care Needs, as well as birthing hospitals throughout the state. This data system was the first of its type within the Maternal and Child Health Branch and is now complete with detailed reporting options for KBSR staff. State Systems Development Initiative Grant funding also supported this project.

The KBSR staff conducts medical record abstraction at birthing hospitals throughout Kentucky. Medical record abstraction is extremely important to the Registry, as much pertinent data is simply not conveyed or is inaccurate on Vital Statistics records and hospital discharge data. Once potential congenital anomalies are identified at a particular hospital (or grouping of hospitals), they are contacted and records are abstracted. Once commonly occurring errors have been identified, trainings for health professionals working with hospital records will be planned with the expectation of better data as a result of this process.

Medical record abstraction has taken place since 1998 for the following congenital anomalies: neural tube defects, Down syndrome, cleft lip with or without cleft palate, diaphragmatic hernia, omphalocele, gastroschisis, trisomy 13 and trisomy 18.

Working with data about birth anomalies occurring within Kentucky is just a piece of the Registry. With this information, interventions for some of these can be applied and families who are challenged with these health problems may be directed to resources and support services. This is the true mission of the Kentucky Birth Surveillance Registry.

In 2002, the law related to the Kentucky Birth Surveillance Registry data collection was amended. Legislative successes include mandatory laboratory reporting for children age birth to five and voluntary outpatient reporting. The addition of mandatory outpatient reporting was unsuccessful during this term. KBSR currently does not collect prenatal testing data, and would not include pregnancy losses prior to 20 weeks gestation.

Conditions added for abstraction in 2002 included fetal alcohol syndrome, renal agenesis and infants of diabetic mothers. In 2003, selected heart conditions have been abstracted. These include: common truncus; transposition of the great vessels; tetralogy of Fallot; common ventricle; endocardial cushion defects and hypoplastic left heart. KBSR has hired a local health department health educator (.25FTE) to assist with data abstraction and prevention activities in Western Kentucky.

Data abstracted from 1998 - 2002 is published on the Department for Public Health website at http://chfs.ky.gov/dph/ach/kbsr.htm. Additionally, a manuscript on Neural Tube Defects rates in Kentucky is being submitted to the Kentucky Medical Association for inclusion in their publication. Other activities currently underway include quality assurance and auditing protocols to improve data quality from participating hospitals, educational activities and collaboration with statewide family planning clinics to facilitate preconception health promotion including the identification of high-risk individuals and referral to appropriate services.

The Kentucky Birth Surveillance Registry now has reporting of birth defects from cytogenetics laboratories, level III neonatal intensive care units, and outpatient genetics clinics. These additional reporting sources have improved the completeness of ascertainment of birth defects. Abstraction of all major structural birth defects will continue during this year. KBSR will have five years' worth of data

this year for analysis that will include rates as well as geographical mapping. Data has been provided to numerous agencies in the past year including the National Birth Defects Prevention Network. Two research proposals were also submitted for Institutional Review Board approval to access KBSR data. One study focused on an epidemiological analysis of gastroschisis in Kentucky, while the other study was evaluating the association between maternal smoking and the occurrence of cleft lip and/or palate.

KBSR plans to develop interstate agreements with bordering states' surveillance programs or individual hospitals to further improve case ascertainment in the upcoming year. Staff will continue to monitor the timeliness of data collection through the registry. The service referral component will be implemented as the protocol developed for this purpose has received legal approval. Educational efforts for health professionals and the general public on birth defects and genetics will continue in the upcoming year.

The Department for Public Health with the University of Kentucky, College of Dentistry is conducting oral health screenings of school children (3rd and 9th graders) throughout the Commonwealth of Kentucky as part of the Kentucky Children's Oral Health Surveillance Program (KCOHSP). A survey conducted in 2000-2001 resulted in enlightening data on the oral health status of Kentucky's school children. Kentucky's 2001 Children Oral Health Survey showed that nearly one-third of a sample of 2-4 year olds were affected by early childhood caries (ECC). 30% had severe ECC, 39% had never been to a dentist and 35% of their parents had not seen a dentist in the last year. Of these children, 39% had Medicaid, 15% had KCHIP and 29% had private dental insurance.

When school-aged children (3rd and 6th graders) were surveyed, 57% had caries experience with 29% having visible decay, 51% reported bleeding gums and 15% had signs of gingival inflammation. 20% reported having a toothache in the past month and had not seen a dentist in the last year. Only 29% of these children had sealants on any molar.

This new surveillance program will monitor the changes that have taken place since the first survey in 1987 and the more recent survey that was reported in 2001. To best design and implement preventive and restorative programs to enhance the oral health status of our children, these new data are vital to their success. Data will be collected over the next three school years to obtain a statistically valid sample. Each individual screening will take about 2-3 minutes and a report to parents will be given to each participating child to take home. The Department of Education is a partner and supports this assessment effort as the important next step in getting children healthier and thus facilitating learning. Children do not learn well if they have oral infections that can cause pain, swelling and inattention. Effective preventive programs have been shown to decrease the level of oral infections in children.

To address this concerning threat to the overall health of children in Kentucky, Dr. James Cecil, D.M.D, M.P.H., Administrator of the Office of Oral Health, within the Department for Public Health, imparts a vision which provides access to care and assurance of services to all children within the Commonwealth.

The fluoride varnish program for preschoolers and a sealant program for school-age children both began in July 2003.

The Strategic Planning Process has been a collaborative effort between the Kentucky Department of Public Health and the University of Kentucky School of Public Health Dentistry. The process began with a selection of over 200 key players throughout the state to be a part of the planning process. This listing was eventually culled down to approximately 125 participants who participated in a six-question electronic survey (a SWAT Analysis) which asked for input on the strengths and weaknesses of the provision of oral health services in Kentucky; identification of additional factors that would have a positive (and negative) impact on the achievement of oral health and a vision (ideal state) for oral health. These questions generated many responses which have been condensed and provided the Oral Health Strategic Planning Executive Committee with a baseline from which to develop draft vision, mission, plus-delta and value statements. The large group will convene to refine the work

previously done by the Executive Committee and to generate specific steps for addressing oral health issues for all Kentuckians. Finally, the plan will be drafted and written.

Regional dental treatment centers will be established throughout Kentucky to provide service availability for children and adults alike. Several partnerships are already in place to make these centers of care a reality including one in Hazard (Eastern Kentucky) and in Madisonville (Western Kentucky). With improved access to care, specialized programs for all populations will be developed in our state. This series of programs and assessment tools, will have a positive impact on the oral health of Kentucky's children.

These are just a few examples of the health challenges facing our state. Others, such as obesity in children and childhood injury (particularly motor vehicle injury), are equally important and are discussed within the appropriate performance measures later in the narrative.

Kentucky's Public Health Successes in Maternal and Child Health

While many public health challenges face Kentucky's health providers, there have been some exciting success stories over the past decade in Kentucky.

Kentucky's KIDS NOW Early Childhood Development Initiative has provided millions of dollars for the support of programs impacting the early years of a child's life; from preconception to entry into the childcare setting. Performance and outcome measures associated with these programs are being carefully analyzed and already show positive results on the well-being of Kentucky children. Details about this nationally acclaimed early childhood initiative and the partnerships that make it work are provided throughout the document.

Additionally, the rate of teen birth has declined from past years (from 35.3 per 1,000 in 1997 for 15-17 year olds to 27.6 per 1,000 in 2003) and is now approaching the national rate for this performance measure. The most substantial declines have been seen throughout Eastern Kentucky counties; where poverty is still a great concern.

In 2004, over 86% of women in Kentucky entered prenatal care in the first trimester and 82% had adequate or above adequate prenatal care, based on the Kotelchuck Index. Additionally, childhood injuries and infant mortality have steadily decreased while access to health care for Kentucky children has steadily increased through the advent of KCHIP, Kentucky's Children's Health Insurance Program.

The Title V Program -- Access, Assurance and Policy Development

Traditionally, the Title V program has focused on providing access to maternal and child health services whether it be through supporting local health departments or through contracts with universities to deliver services within the community setting and on site for the maternal and child health population. Although this continues to be the focus for the Title V programs, a changing health care environment has opened other opportunities to improve the health of women, infants, children and children with special health care needs. Assurance through partnerships, cooperative agreements and contracts will be discussed throughout the Title V Annual Report and Application.

Local Health Departments continue to be the presence of the Department for Public Health at the local level. As in past years, the majority of Title V funding is allocated directly to local health departments to support their activities benefiting the maternal and child population. Local health departments conduct community needs assessments on a regular basis which guide their programming priorities while the Department for Public Health provides regulatory guidance and standards of care; in addition to training opportunities and other resources.

In general, the statewide trend is that the direct community services for maternal and child health is occurring more frequently in traditional medical homes than in years past. When this is the case, local

health departments assume an assurance role.

Factors influencing this trend include more public financing (such as KCHIP) and more effective healthcare systems utilizing a Primary Care Provider. This is occurring more commonly in the areas of family planning, prenatal and child preventive services. Some rural counties do lack key health providers such as OB/GYNs and Pediatricians. In these cases, local health departments do provide preventive and direct clinical services.

The Kentucky Public Health Practice Reference (PHPR), developed by the Department for Public Health, serves as the guidance for clinically based information to support patient-centered health care provided by local health departments. Additionally, the PHPR provides supportive information to assist the professional in providing services within the community; outside the clinic setting.

Guidelines included in the PHPR will enhance the health care professionals knowledge and understanding of population-focused practice and reflect current information and recognized treatment recommendations from appropriate literature and authorities. These guidelines are the minimum standards of care and may not be reduced. If a local health department desires to provide an enhanced level of care, they may develop local protocols. Additional protocols and guidelines that are desired at the local level must be jointly developed by nurses, advanced practice nurses, physician assistants and their collaborating physicians, as indicated. The entire PHPR and semi-annual updates to the document will soon be available on the DPH website at: http://hfsnet.state.ky.us/dph/Table_of_Contents.htm

All local health departments clinical and administrative operations are reviewed on a regular basis under the Division of Adult and Child Health Improvement's Quality Assurance Review Process. Areas reviewed include the Breast and Cervical Cancer program, the Family Planning program, Child Fatality Review, Pediatric clinical services and lead poisoning prevention. Using Kentucky's Public Health Practice Reference as the quality assurance standard, a team of registered nurses visits each local health department to conduct staff interviews and clinical record reviews. Issues for discussion include barriers to access, continuing education needs and data collection quality. Specific to the family planning program, appropriateness of care and adherence to the federal guidelines is ascertained during this review. Following an exit interview with key staff, a written report is prepared by the team and the local health department responds with a quality improvement plan to address identified issues in a timely manner.

Universities are also important partners with the Department for Public Health in the continuum of care for Kentucky's maternal and child populations. Kentucky's two tertiary centers are the University of Kentucky (Lexington) and the University of Louisville. They, as well as Eastern and Western Kentucky Universities, Kentucky State University, Pikeville School of Osteopathy and others collaborate on many levels including training for health care providers, research and the provision of resources for providers throughout the state.

Details about specific contracts are discussed under Section III, E - State Agency Coordination.

Other Key Partners in Maternal and Child Health

ACHI/Federally Funded Primary Care Centers
Kentucky has thirteen primary care sites that receive federal funding; and these have approximately twenty-six service locations in underserved areas of the state. In addition to offering primary care services, other services offered at these locations include: Dental, Enabling, Mental Health/Substance Abuse, OB/GYN, Other Professional Services and Specialty Care. Formal linkages and collaborative efforts between primary care centers and local health departments vary throughout the state. Two sites (Lexington-Fayette County and Louisville Metro-Jefferson County) are formally linked with their respective local health departments.

Other Agencies and Non-Profits

In addition to governmental linkages, ACHI also collaborates with a number of associations, voluntary organizations and advocacy groups with an interest in maternal and child health issues.

The Pikeville College School of Osteopathic Medicine was established in 1996 with $10 million from private corporate and government donors. Its goal is to address medically underserved central Appalachia, which despite a push to recruit doctors still has just one primary care physician for every 1,200 people and the ratio is even lower in the region's most economically distressed counties. The College draws many of its students from the central Appalachia region and strives to send its graduates back to the same region to increase the number of Primary Care Physicians. There are currently 270 at the Pikeville School, with 180 more going through the three-year residency programs in osteopathic medicine, which places a special emphasis on the interrelationship of organs and body systems.

DPH is utilizing the opportunity to work with this key group of rural medical professionals, by providing Oral Health education to faculty, students, interns, and residents. This project will facilitate the training of osteopathic physicians to recognize oral health problems in their patients and to make appropriate referrals to oral health professionals. The ultimate objective is to improve the oral health status of Kentuckians, especially children and pregnant women.

The March of Dimes Birth Defects Foundation: The March of Dimes is another strong partner of the Department for Public Health. ACHI staff participates on the Greater Kentucky Chapter State-Level Program Service Committee and in the allocation of nearly $130,000 for direct community grants supporting maternal and child health programs at the local level. Additionally, staff work to implement relevant programs and projects; such as preconceptual planning, prenatal lead poisoning prevention and prematurity/low birthweight awareness and prevention.

Other key partners include the Kentucky Perinatal Association, Kentucky Early Childhood Authority, the Migrant Health Coalition, the Foundation for a Healthy Kentucky, Kentucky Child Now, the Kentucky State Coalition of Primary Care and the Kentucky Disabilities Coalition, etc.

Steve Davis, M.D., Deputy Commissioner for the Department for Public Health, believes that "targeting an inch wide and a mile deep" will impact a health issue effectively and quickly. And, that a unified effort across the state by local health departments, universities, hospitals and private providers is the key to solving Kentucky's health challenges for the maternal and child population into the 21st century.

The Commission's Role in Assuring the Health and Well-Being of CSHCN

The Commission for Children with Special Health Care Needs has a long history dating back to 1924 when it was created by the State Legislature in response to a request from the Rotary Club to provide treatment to children with orthopedic conditions through itinerant clinics across the state. The focus on community-based systems of care continues today. In addition to being a direct services provider, the Commission has assumed a leadership role in assuring state and local systems of care for children and youth with special health care needs (cyshcn) and in promoting a broader definition of health for CSHCN and their families as defined by the World Health Organization: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." This expanded focus has positioned the Commission to take a leadership role in closing the achievement gap by championing the President's New Freedom Initiative and the No Child Left Behind Act among other state and local agencies, the faith community, and community based organizations on behalf of the Cabinet for Health and Family Services.

As a national leader in developing systems to support the transition of cyshcn to adulthood, Kentucky became the first state to develop a Title V performance measure for transition to adulthood in 1997. The focus of staff has evolved from clinic care to care coordination/case management. The development of personal and family competencies that support successful transition are integral

components of care coordination and patients five and older are counseled and assisted in transition to adult health care. Within the past year, the Commission has been primary grant writer for two community-based efforts to secure funding through the Administration for Developmental Disabilities and the Department of Labor for services to children and youth with disabilities and their families through comprehensive one-stop centers. Because schools are often the focal point for children and youth and their families, the Commission has developed a strong and productive relationship with the Division of Exceptional Children Services, Kentucky Department of Education. In doing so, we have taken steps to build an infrastructure at the community level that supports both the child's health and educational needs.

Because of the complexity of their medical needs we sometimes forget that children and youth with special health care needs are first and foremost children and youth. They are subject to the same behavioral health risks as their non-disabled peers. Addressing health promotion and injury prevention among children and youth with disabilities represents a new challenge to the Commission. "Graduate" surveys of youth exiting the Commission and Shriner's Hospital (Lexington) found that youth smoke and drink alcohol at levels of typical youth in Kentucky. The surveys also show that graduates use the emergency room at almost double the rates of typical youth and over 1 in 4 of the visits were due to trauma. Obesity and lack of physical activity among CSHCN are clearly issues that must be addressed through patient education and care coordination and through community and school-based interventions that are done in collaboration with our education and public health partners.

The highly successful implementation of the universal newborn hearing screening program has provided the Commission a foundation for population-based public health practice and the capacity to respond to future opportunities for advancing early and continuous screening. While preparing for the needs assessment we realized we were being presented with an additional opportunity to expand our focus using a broader definition of CYSHCN than those enrolled in the Commission's Title V specialty medical services program. The availability of data from the 2001 National Survey of CSHCN coupled with the Child & Adolescent Health Measurement Initiative provides a platform from which we can now assess the needs of cyshcn in Kentucky ages 0-17. Previously, much of our reporting was limited to cyshcn enrolled in the Title V specialty medical program, which accounted for less the 10,000-12,000 of the state's estimated 156,000 cyshcn.

As the Commission proceeds with the MCH 5-year needs assessment, cultural and linguistic competency will be foremost in our minds. Prevalence statistics from the National Survey indicate that 14.4% of the cyshcn in Kentucky are Hispanic; 16.2% are Black; and 20.3% are Multi-racial. Approximately 1 in 3 of Kentucky's cyshcn have family household incomes at or below 199% of the Federal Poverty Level. Because cultural competence is a developmental process that evolves over an extended period, the Commission has committed to this process by designating a Title VI coordinator whose job is to assure that policies and structures are developed to assure that the agency works effectively cross-culturally.

The National Survey of Children with Special Health Care Needs can be accessed at www.cshcndata.org.

B. AGENCY CAPACITY

Assurance for the Health of Kentucky's Women and Children

Kentucky's attention to the needs of its women and children continues to grow stronger. Prior to the federal legislation that created SCHIP, the Cabinet for Health Services had a small work group that designed a plan about how public health could provide or assure access to quality care for our most vulnerable populations. While this plan was being created, federal funding came through the SCHIP program, which became KCHIP in Kentucky. In 1998, 65 million dollars was designated to support health services through KCHIP and Kentucky has been lauded nationally for its efficient enrollment process and success in identifying children who qualify for this program.

In the 2000 Kentucky Legislative Session, a radical new program was created called "KIDS NOW!" This comprehensive plan addresses issues for children from the prenatal period (folic acid supplementation) to birth (home visitation and newborn hearing screening) through the time that they attend childcare. This program added $ 55 million new dollars to programs centered on children in Kentucky, and in excess of $ 30 million dollars was allocated specifically for programs dealing with maternal and child health. Funded through the national Master Tobacco Settlement, the Kentucky General Assembly passed a bill that allowed 25% of this funding to be directed to very young children and families; thereby assuring significant and ongoing support for this population.

Discussion follows regarding the delivery of care system in Kentucky for the maternal and child population.

***** Capacity - Kentucky Statutes *****

State statutes relevant to Title V programs are listed below and may be viewed in their entirity at http://lrc.ky.gov

Maternal Health

KRS 194A.095 Directs that an Office of Women's Health be established within the Cabinet for Health and Family Services.

KRS 214.160 Requires syphilis testing for pregnant women.

Perinatal Health

KRS 211.651 -- KRS 211.670 Authorizes the Birth Surveillance Registry administered by the Division of Adult and Child Health Improvement. Allows Birth Surveillance Registry personnel to review and receive records from medical laboratories and general acute-care hospital if voluntarily participating in keeping a listing of both inpatients and outpatients.

KRS 214.155 Authorizes newborn screening for inborn errors of metabolism and other hereditary disorders.
This regulation is currently being revised to reflect the expanded newborn screening legislation that was passed in the 2005 Kentucky General Assembly.

KRS 304.17A-139 to provide for a $ 25,000 cap on coverage for inherited metabolic diseases on medical formulas and a separate cap of $ 4,000 on low-protein modified foods for each plan year.

KRS 311.6526 to requires the Emergency Medical Services Program for Children to collaborate with the Cabinet for Health and Families Services and require guidelines for responding to abandoned infants, including preserving the confidentiality of the parent, and define "newborn infant" as an infant less than seventy-two (72) hours old. Providing implied consent for treatment and confidentiality for the person releasing the infant with the provision unless indicators of child abuse or neglect are present.

HB 108 AN ACT relating to the protection of unborn children.
Create a new section of KRS Chapter 507 to include unborn child after viability within the definition of "person" for the purposes of the criminal homicide statues to criminalize fetal homicide; create a new section of KRS Chapter 532 to provide a sentence enhancement for criminally causing a miscarriage or still birth of a fetus before viability.

Pediatric

KRS 200.650 -- KRS 200.676 Kentucky Early Intervention System/ First Steps.

KRS 211.680 -- Authorizes the Department for Public Health to coordinate efforts to reduce the number of child fatalities through reviews of unexpected child deaths.

KRS 211.900 -- KRS 211.905 Authorizes comprehensive lead poisoning prevention services.

KRS 213.410 -- Authorizes SIDS services.

KRS 214.034 -- KRS 214.036 Establishes immunization requirements for children.

KRS 214.185 Permits diagnosis and treatment of minors for contraception, sexually transmitted diseases and pregnancy related care without parental consent.

HB353 To allow public and private school students to self-administer asthma medications when the school receives written authorization from the parent and health care provider.

KRS Chapter 95A.200 to establish a Safety Education Fund to be administered by the Commission on Fire Protection Personnel Standards and Education to initiate education programs in the public schools and other agencies to reduce and prevent injuries and the loss of life; the commission shall promulgate administrative regulations to establish the criteria for providing funds to initiate injury prevention curricula and training programs throughout the state.

Children with Special Health Care Needs

KRS 194A.030(7) Creates the Commission for Children with Special Health Care Needs

KRS 200.460 -- KRS 200.499 Commission for Children with Special Health Care Needs. Establishes the organization and guidelines for providing services to children with special health care needs.

KRS 200.550 -- KRS 200.560 Provides for the detection and treatment of children and adults with bleeding disorders.

KRS 211.645, 211.647 and 216.2970 Universal Newborn Hearing Screening.

KRS 213.046 When a birth certificate is filed for any birth that occurred outside an institution, the Cabinet for Health and Family Services shall forward information regarding the need for an auditory screening for an infant and a list of options available for obtaining an auditory screening for an infant.

911 KAR 1:070. (Formerly 902 KAR 4:070) Implements the services of the Commission for Children with Special Health Care Needs.

MCH General

KRS 211.180 Gives the Department for Public Health the responsibility for public health, including improving the health of mothers, infants and children.

HB 67 To allow ARNPs and RNS to distribute nonscheduled legend drugs from a Department for Public Health approved list in local health departments.

KRS 156.501 established a full-time position of education school nurse consultant within the Department of Education and specify employment requirements and job duties to include development of protocols for health procedures, quality improvement measures for schools and local health departments and data collection and reporting.

2005 Legislation

SB 2 AN ACT relating to health information. Creates the Kentucky e-Health Network Board to oversee the development, implementation, and operation of a statewide electronic health network.

SB 24 AN ACT related to expanded newborn screening.

SB 56/HB 170 related to drugs. Requires the restriction of the sale and display of drugs containing ephedrine or pseudoephedrine; requires identification and limits the quantity available for purchase. This legislation was a part of Governor Fletcher initiative as a way to stop or reduce the production, usage and sale of Methamphetamine in Kentucky.

SB 172 An ACT relating to health and nutrtion in schools. Requires 30 minutes of physical activity each day in schools or 150 minutes per week; to prohibit, beginning with the 2006-2007 school year, a school from preparing or serving deep-fried foods in the cafeteria during the school day, require each school to publish a school menu that specifies nutritional information: require each school to limit access to no more than one day each week to retail fast foods in the cafeteria. Also created the Get Healthy KY! Board.

HB 267 State Budget Bill includes funding for Smoking Cessation Counseling for Pregnant Women covered by Medicaid.

HB 272 AN ACT relating to revenue and taxation. Changes many provisions of state income tax, corporate tax and cigarette excise tax. For low income families the tax threshold raised to the federal poverty level. Cigarette excise tax raised from 3 to 30 cents. 1 cent of the increased cigarette excise tax is dedicated to cancer research.

HB 304 AN ACT relating to international adoption. Requires Kentucky courts to recognize a final adoption decree from a foreign country.

HB 323 AN ACT relating to the establishment of the Off-Road Motorcycle and ATV Commission. One member of the Commission is to be the Executive Director of the Brain Injury Association of Kentucky.

Capacity: Early Childhood Development - "KIDS NOW!" Early Childhood Development Program

"KIDS NOW!" Early Childhood Program brought $55 million dollars from the tobacco settlement to Kentucky's maternal and child population in 2000. These funds are used in implementing programs such as folic acid education, immunizations, voluntary home visiting, early childhood mental health, universal newborn hearing screening, substance abuse treatment for pregnant women and multiple programs enhancing early child care and education.

Significant program activities under this initiative have been ongoing for the Commission for Children with Special Health Care Needs and the Division of Adult and Child Health. The programs working to enhance early childcare, health and education have allowed additional opportunities to collaborate with the Division of Child Care on general child development, data collection and management and quality issues. For additional information about "KIDS NOW!", visit their website at http://www.kidsnow.ky.gov

Capacity: Division of Adult and Child Health Improvement

The Division of Adult and Child Health Improvement is located within the Department for Public Health. Steve Davis, M.D., has been appointed Deputy Commissioner of the Department for Public Health but remains the Acting Director of the Division of Adult and Child Health Improvement and Title V Director until Ruth Ann Shepherd, M.D., F.A.A.P., is available to assume the duties September 1, 2005. Dr. Shepherd will have administrative responsibility for a significant number of programs outside of the MCH program area and a review of the Division is discussed below.

The Division of Adult and Child Health Improvement (ACHI) is comprised of five branches; Maternal and Child Health, Chronic Disease Prevention and Control, Nutrition Services, Health Care Access, and Early Childhood Development. Effective March 1, 2004, the Division of Adult and Child Health Improvement became the agency designated by the Cabinet for Health and Family Services to administer the state's Part C (IDEA) early intervention program called First Steps and is located in the Early Childhood Development Branch.

This Division has multiple opportunities to collaborate across branches thereby increasing the potential to have a greater impact on the health care delivery system that affects women and children. Programs such as breast and cervical cancer, diabetes, oral health, tobacco cessation, school health, WIC, Five-A-Day Campaign, and Healthy People 2010 objectives relative to the Preventive Health Block Grant are housed within the Division. Discussion follows about service provision from the branches which directly impact maternal and child health; the Maternal and Child Health Branch, Nutrition Services Branch, Chronic Disease Prevention and Control Branch, the Health Access Branch, and the Early Childhood Development Branch.

-Maternal and Child Health Branch: The Maternal and Child Health Branch (MCH) is divided into two sections, Women's Health and Pediatrics. The Women's Health Section will implement health prevention education and clinical services in the Breast and Cervical Cancer program, family planning and maternity care. Abstinence and teen pregnancy prevention programs are also promoted by this section. The Pediatrics Section includes child preventive health screenings (Well Child and EPSDT), child lead poisoning prevention, Child Fatality Review and Injury Prevention program and the Coordinated School Health Initatives. Coordinated School Health is a recent addition to the MCH Branch, Pediatric's section and is a collaborative effort with the Kentucky Department for Education. The branch assures quality programs in all areas of MCH programming and policy through coordination, collaboration and technical assistance to partners throughout the state.

-Nutrition Services Branch: The Nutrition Services Branch includes five programs; the ACHI Nutrition Program, WIC Program, 5 A Day Program, the Farmers' Market Nutrition Program (FMNP) in collaboration with the Kentucky Department of Agriculture and the Obesity Component of the Centers' for Disease Control (CDC) Chronic Disease Prevention and Health Promotion Programs Grant.

The ACHI Nutrition Program provides medical nutrition therapy to eligible clients in 110 of 120 counties and community nutrition education services to all counties. The Program goals are to; promote healthy eating that follows national guidance policy, impact policy that improves access to healthy foods, and promote healthy weight among adults and children. Besides providing medical nutrition therapy to patients with problems such as obesity, diabetes and cardiovascular disease, nutritionists conduct in-service education for staff. The community programs use proven strategies such as the 5 A Day Program, Choose 1% or Less Program, weight loss classes, cooking classes, and menus for day care centers and schools.

The federally funded WIC Program sets the standards for nutrition services. WIC's primary focus is to provide nutritious foods, nutrition education and, when appropriate, breastfeeding information and appropriate social and medical referrals for low-income pregnant, breastfeeding and postpartum women, infants, and children who are at nutritional risk. The program is also responsible for promoting breastfeeding, resulting in 31 percent of low-income women breastfeeding.

The Nutrition Services Branch, in collaboration with the Department of Agriculture, administers the WIC Farmers' Market Nutrition Program (FMNP). FMNP provides participants in the WIC Program with coupons to purchase fresh fruits and vegetables at local farmers' markets. Through this program, WIC participants receive the nutritional benefits of fresh fruits and vegetables and nutrition education concerning 5 A Day. Forty-one (41) local agencies/sites, approximately 23,313 WIC participants and approximately 600 farmers received the benefits of this Program.

Additionally, this Branch coordinates the CDC Obesity Prevention Grant, discussed in detail under the

"Other Program Activities" section.

-Chronic Disease Prevention and Control Branch: The Chronic Disease Branch is responsible for decreasing the morbidity and mortality from chronic diseases. Emphasis is on prevention and risk factors that can be reduced through healthy lifestyles. The branch puts a significant amount of its effort into decreasing substance abuse including the use of tobacco, alcohol and legal and illegal drugs; increasing physical activity and improving the eating habits of Kentuckians. The branch's programs include cardiovascular health, diabetes, substance abuse prevention, tobacco, health promotion, asthma, arthritis and home health. This branch works closely with the Maternal and Child Health Branch on numerous initiatives including prenatal smoking cessation, maternal diabetes and healthy lifestyles for Kentucky's women of childbearing age and their children.

-Health Care Access Branch: FY 2002 saw the creation of the Health Care Access Branch consisting of the primary care and oral health programs that were formerly part of the Maternal and Child Health Branch. This branch was established to give focus and emphasis to activities conducted by the Division of Adult and Child Health Improvement that address issues of accessibility and availability of essential primary medical and oral health services at the community level.

The Primary Care Program has a cooperative agreement with the federal Department of Health and Human Services (DHHS) to provide current data on health professionals in Kentucky that is used by the Secretary of DHHS in designating Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs) in Kentucky. Branch staff obtains licensure data from the Kentucky Board of Medical Licensure and conducts surveys of local physicians to determine the number of primary care physicians actually practicing in Kentucky counties and the degree to which these physician practices serve the uninsured and underinsured populations.

Following the identification and designation of HPSAs and MUAs, staff of the primary care program participates in several programs aimed at increasing the number of health professionals available to serve these areas including the Conrad State 30 program, the Appalachian Regional Commission J-1 Visa Waiver Program and the National Health Service Corps.

The Division of Adult and Child Health Improvement is a partner with Healthy Kentucky, a nationally recognized public/private program that seeks to provide health and medical services to Kentuckians with incomes below the federal poverty level who are not eligible for Medicaid and have no other health insurance coverage. Staff of the Health Care Access Branch answers the Kentucky Physicians Care (KPC) hotline to provide information about the program and make referral to volunteer physicians, pharmacists, and other participating health care providers.

The Oral Health Program has attempted to make medical professionals as well as non-professionals aware of the linkages of oral health with general health (i.e., diabetes, heart disease, preterm low birth weight babies, early childhood caries, and others) through disease prevention and health promotion activities. Our vision is that oral health is integral to general health; most oral diseases are highly preventable using evidence-based approaches.

Early Childhood Development Branch: The Early Childhood Development Branch implements statewide services for preventive health in very young children, education to the caretakers of those very young children and direct interventions to children identified as needing developmental and/or social and emotional services. This branch promotes coordination and collaboration between the three major birth to age three programs in the state for both children with and without developmental concerns.

This branch oversees "KIDS NOW!" programs, Kentucky's early childhood initiatives that include home visiting through the HANDS program, Healthy Start in Child Care, Early Childhood Mental Health services and the early intervention Part C (IDEA) program called First Steps for children birth to age three who have a suspected developmental delay or a medical condition known to cause a developmental delay.

Effective August 1, 2005, the Kentucky Birth Surveillance Registry, the Newborn Metabolic Screening program, Genetic and Diagnostic services will be relocated to the Early Childhood Development Branch. The Kentucky Birth Surveillance Registry provides critical data and information regarding children birth to five with birth defects and was discussed in the Overview Section III.A.

Capacity: Local Health Departments

The degree of coordination and cooperation between ACHI and local health departments cannot be overstated. Kentucky has 16 district health departments and 40 independent health departments. Local health departments are the primary prevention presence for maternal and child health services in Kentucky. Traditionally, this has meant that most of the Title V Block Grant funds have supported the direct clinical and preventive services in the local health departments. State staff continue to create new opportunities for local health departments to partner with new entities and transition into community education and services.

Capacity: Commission for Children with Special Health Care Needs*

A Memorandum of Agreement between the Commission and the State Division of Disability Services assures that children who apply for SSI benefits receive referral and outreach services.

Families may access Title V/CSHCN services through 14 regional offices across the state. Direct medical services are provided to children with certain conditions, both congenital and acquired. See locations of regional offices and list of conditions treated by the Commission at http://chs.ky.gov/commissionkids/clinics.htm. The Commission provides family-centered, community-based care by sending treatment teams including nurses and pediatric specialty physicians at clinic sites in 26 of the state's 120 counties. Clinics for some complex conditions that require multi-disciplinary treatment teams are held only in Louisville and Lexington due to availability of providers. Families in need receive financial support to assist with travel and/or lodging in order to attend these clinics or receive hospital services.

The Commission maintains a local provider network through contracts with approximately 350 pediatric specialty physicians and 150 dentists throughout the state. Other medical and ancillary services e.g., therapists, pharmacists, audiologists are available through contracts with local community providers. The Commission also contracts for foreign and sign-language interpretative services to assure access to care for families of diverse cultures including those with hearing impairments. These services are available in each Commission region. A need for interpretative services is identified during intake and arrangements are made for appropriate service prior to clinic or other Commission appointments.

Previously, the Commission had reported on the transfer of the State's early intervention services program, which is partially funded under the Individuals with Education Act (IDEA) Part C. Effective March 1, 2004 this program was transferred from the Commission to the Division of Adult and Child Health Improvement. In 2002 in conjunction with the program transfer, the Commission initiated an extensive planning process involving over 70 stakeholders, to study and recommend actions for improving agency capacity to respond to the health and developmental needs of cyshcn. Since then, the Commission has added a developmental transition checklist to the Internet-based case management and reporting system (CUP). Work is now underway to develop a patient and family centered care plan for use by the nurses, social workers and other health care professionals that serve as care coordinators. The care plan will capture child and family outcomes and improve our capacity to measure and monitor the extent to which are delivering comprehensive coordinated care and achieving the other MCHB performance measures.

In 2004 the Commission secured a Family Support 360 Planning Grant from the Administration for Developmental Disabilities to provide services to persons with disabilities in an integrated one-stop

setting. Partnering with KY-SPIN, Inc. (KY Special Parent Involvement Network- the state Parent Training Information grantee) and Seven Counties Services, Inc. (the regional mental health/ mental retardation/developmental disabilities agency), the Commission initiated a community planning process in the Louisville Metro to develop a transition and self-determination resource center in the existing network of one-stop health, education, and human services centers known as the Neighborhood Place. As principle investigator on this grant, the Commission has expanded its role from specialty care provider to include community development and integrated systems development. Though the Commission was not awarded the implementation grant we and all the original partners, 7 Counties, KY-SPIN, were committed to pursuing the established goals of developing a transition resource center for individuals with disabilities and their families. These centers will increase opportunities for families to connect with services and supports. An advisory committee has been established and meets monthly. Ultimately, community partners will develop a training packet to educate community members about on going issues faced by the disability community, existing laws designed to protect the disabled, and to help staff communicate more effectively with families. We plan to implement a statewide campaign to educate stakeholders at the state and community levels about the needs of cyshcn using the National Survey of CSHCN and other data. Building upon community partnerships formed during the implementation of universal newborn hearing screening and vision screening for children entering school under the KIDS Now initiative, our goal is to act as a convener and engage our partners to develop a shared vision and plan for achieving a system of care unique to their community.

The Commission is working to continue to expand the capacity of its health information system to fully support the core functions of public health as relates to cyshcn: to assure early identification and screening leading to diagnosis, treatment, and access to community-based systems of care; to provide comprehensive care coordination with the context of the medical home; to identify and eliminate disparities in health status outcomes; and to support program accountability through the collection, analysis, and reporting of data and progress in meeting performance targets. To this end, grant funds from MCHB for State Systems Development Initiative (SSDI) will be used to support the link between the Title V cyshcn database (including UNHS) with vital records and other public health data systems maintained by the Cabinet for Health and Family Services.

Note: Collaborative ventures between the Division of Adult and Child Health Improvement (ACHI) and the following organizations are discussed in detail within Section III E -- State Agency Coordination.

Additional discussion is included within pertinent performance measures and indicators.
1. Commission for Children with Special Health Care Needs
2. Local Health Departments
3. Department for Medicaid Services
4. Department for Mental Health and Mental Retardation
5. Other State Agencies
6. Tertiary Centers (University of Kentucky and University of Louisville)
7. Other Partners (March of Dimes, etc.)

Kentucky School of Public Health

A cooperative venture is being undertaken by Kentucky's leading educational institutions to increase the capacity for public health professionals. The University of Kentucky and the University of Louisville are the cornerstones of the Kentucky School for Public Health. The University of Kentucky School of Public Health is committed to graduate education and offers the Master of Public Health and Doctor of Public Health degrees. Through its Institute for Public Health Research, the University of Louisville offers the Master of Science in Public Health and Doctor of Philosophy degrees. An affiliation agreement between the two institutions outlines a plan to focus on cooperative efforts in teaching, research, and service in public health and to facilitate student matriculation and study at either institution.

Other institutes (such as Eastern Kentucky University in Richmond, Western Kentucky University in

Bowling Green and the Pikeville College School of Osteopathic Medicine) are working in partnership with UK and UL to make this a truly statewide effort. For more information about the Kentucky School for Public Health, please visit their website at http://www.mc.uky.edu/kysph/

Kentucky Public Health Leadership Program

The ability of future public health professionals to positively impact the health of Kentucky's citizens has been greatly enhanced through the development of Kentucky's Public Health Leadership Program.

Employees of the Division of Adult and Child Health Improvement staff, as well as local health department staff, annually attend the year-long Kentucky Public Health Leadership Institute (KPHLI), a cooperative venture between the University of Kentucky (Lexington), the Good Samaritan Foundation, the Kentucky Department for Public Health and the Centers for Disease Control and Prevention.

The Kentucky Public Health Leadership Institute began in March 2000. This multi-disciplinary leadership development opportunity is for individuals involved in Public Health within the state. KPHLI serves as a change catalyst for both leaders and public health entities within the state. The institute's goal is to strengthen Kentucky public health by improving the skills of the professionals who administer state, regional and local public health systems.

The contact person for KPHLI is Cynthia Lamberth, MPH, of the University of Kentucky School of Public Health. Curriculum contents include leadership and teamwork, core public health functions, study pertaining to the ten basic essential services and creating a vision for the future for public health, measuring outcomes, changing strategies within a bureaucratic system and budget/finance. More information about the Kentucky Public Health Leadership Institute is available at: http://www.mc.uky.edu/kphli

C. ORGANIZATIONAL STRUCTURE

Office of the Governor

Ernie Fletcher, M.D. was elected Governor of the Commonwealth of Kentucky and took the Oath of Office in December 2003. Governor Fletcher has a B.S. from the University of Kentucky College of Engineering and later graduated from the University of Kentucky College of Medicine. Governor Fletcher has also been an Air Force fighter pilot, a state legislator and was United States Congressman before being elected Governor.

Cabinet for Health and Family Services

One of Governor Fletcher first tasks upon taking office was a reorganization of state government. The Cabinet for Health Services and the Cabinet for Families and Children were consolidated to become the Cabinet for Health and Family Services. The Kentucky Department for Public Health, Division of Adult and Child Health Improvement (ACHI) and The Commission for Children with Special Health Care Needs are included within the Cabinet for Health and Family Services. The Cabinet for Health and Family Services is the state government agency that administers programs to promote the mental and physical health of Kentuckians. The Cabinet includes the following departments: Public Health, Mental Health and Mental Retardation, Medicaid, Disability Determination Services, Human Support Services and Community Based Services. It also includes the Commission for Children with Special Health Care Needs, and the following offices: Ombudsman, Certificate of Need, Inspector General, Legal Services, Fiscal Services, Human Resource Management, Technology, Contract Oversight and Legislative and Public Affairs.

Dr. James Holsinger Jr., M.D. was named secretary of the Cabinet for Health and Family Services by Governor Fletcher. Dr. Holsinger is the former Chancellor of the University of Kentucky Chandler Medical Center. He graduated from Duke University Medical School in 1964 and completed a Ph.D. with a major in anatomy and a minor in physiology at Duke University in 1968. Dr. Holsinger has served in a variety of academic and administrative appointments including time at the Universities of Nebraska, Connecticut, Georgia, Virginia, and the University of Kentucky. Dr. Holsinger also served for 26 years in the Department of Veterans Affairs and was appointed in 1990 by President George Bush as Chief Chief Medical Director for the Veterans Health Administration. In his role as Secretary, Dr. Holsinger has responsibility at the executive level for the management of the state's health and social services programs listed above.

Mark Birdwhistell is the Cabinet Undersecretary for Health Services. Mr. Birdwhistell was the chief executive officer of CHA Health, a Lexington managed care organization that covered 200,000 members. He previously held positions with the University of Kentucky Hospital and the KY Department for Medicaid Services. Mr. Birdwhistell is a graduate of Georgetown College and has a master's in public administration from UK. Mr. Birdwhistell will oversee Medicaid, Public Health, Mental Health and Mental Retardation and Disability Determination Services.

Department for Public Health

In November 2004, Dr. William Hacker was appointed Commissioner of the Department for Public Health (DPH). Dr. Hacker had served as acting commissioner for the department since July 2004 upon the retirement of Dr. Rice Leach. Dr. Hacker joined the Department for Public Health as a Physician Consultant in 2001 and served as Branch Manager for the Public Health Preparedness Branch since 2002, where he has headed up the department's disaster preparedness planning efforts. Prior to joining state government, Dr. Hacker's experience included almost 20 years of private medical practice, as well as serving as the Chief Medical Officer of Appalachian Regional Healthcare, Inc. He is Board Certified in Pediatrics and a Certified Physician Executive. He received both undergraduate and medical degrees from the University of Kentucky.

Dr. Steve Davis, Deputy Commissioner of DPH did his undergraduate studies at Morehead State University receiving a Bachelor of Science degree in Biology. He received his M.D. degree from the University of Kentucky and completed his internship and residency in Pediatrics at the University of Kentucky Chandler Medical Center. Dr. Davis remains Acting Title V Director and Director of the Division of Adult and Child Health Improvement until September 1, 2005. In 2004 Dr. Davis received the Beacon of Promise Award from the Lexington Family Care Center. The Beacon of Promise Award is presented to a public figure who has made an extraordinary contribution to the welfare of children and families.

Sarah J. Wilding, BSN, MPA Special Assistant/Chief Nurse for the Department for Public Health, serves as chief nurse and liaison for over 1200 state and local health department nurses. Ms. Wilding has a Bachelor of Science in Nursing from the University of Kentucky and a Masters of Public Administration from Kentucky State University where her major area of concentration was state government. Ms. Wilding has thirty-two (32) years of nursing experience in multiple health care settings, including, hospitals, corrections, local and state public health agencies, and schools.

The Department for Public Health (DPH) is the only agency in Kentucky responsible for developing and operating all public health programs for the people of the Commonwealth. Kentucky Revised Statute 194.030 created DPH to "develop and operate all programs of the cabinet that provide health services and all programs for the prevention, detection, care, and treatment of physical disability, illness, and disease." Dr. Hacker says "The Department for Public Health is about 400 employees assisting 4000 Health Professionals to care for over 4 million Kentuckians and we touch their lives in some way every day."

DPH is divided among five divisions described below:

- Division of Adult and Child Health Improvement (ACHI) promotes maternal, child and family health by developing systems of care and by promoting and providing preventive health services to at risk populations. (more detail below)

- Division of Epidemiology and Health Policy is responsible for communicable disease prevention and control, disease surveillance and investigation, injury prevention and research, maintenance of vital statistics and health data, including hospital discharge data and county health profiles. This division also publishes various health planning documents including the Kentucky Public Health Improvement Plan and Healthy Kentuckians 2010.

- The Division of Laboratory Services provides analysis and quality control for health department laboratories and reference services to laboratories. The central lab also conducts metabolic screening for all newborns in the Kentucky.

- The Division of Public Health Protection and Safety protects Kentuckians from unsafe consumer products, lead hazards, radiation and other toxic exposure, unsanitary milk, adulterating and misbranded foods, unsanitary public facilities, and malfunctioning sewage systems.

- The Division of Resource Management develops and oversees the Department for Public Health's budget as well as local health department's fiscal planning, allocations and payments, and their administrative and management practices. The division also manages departmental procurement and contracts, information technology and administrative support to local health departments in all 120 counties of the Commonwealth.

Division of Adult and Child Health Improvement

The Division of Adult and Child Health Improvement includes Maternal and Child Health (MCH), Chronic Disease Prevention & Control, Nutrition Services, Health Care Access and Early Childhood Development.

James S. Davis, M.D. is now Deputy Commissioner for the Department for Public Health but remains Acting Title V Director and Director for the Division until Ruth Ann Shepherd, M.D. assumes the duties September 1, 2005.

The Maternal and Child Health (MCH) Branch activities, set forth under the Title V program, are managed by Linda Lancaster, Branch manager and section supervisors for Pediatrics and Women's Health. The mission of the MCH Branch is to provide leadership, in partnership with key stakeholders, to improve the physical, socio-emotional, safety and well-being of the maternal and child health population that includes all of Kentucky's women, infants, children, adolescents and their families.

Children with Special Health Care Needs

Kentucky's "KIDS NOW!" initiative gave the Commission the charge to implement a statewide Universal Newborn Hearing Screening (UNHS). State tobacco settlement funds totaling $1.7 million were allocated for state fiscal years 2001 and 2002 to support the implementation of this initiative. The mandate to implement UNHS necessitated the addition of new staff members and a change in organizational structure.

The Commission's executive office, division directors, and statewide administrative staff are located in the central office in Louisville. The 3 Nurse Service Administrators live and maintain offices in the regions they manage. This level of regional, community-based management allows timely supervision and intervention as issues arise; identification of emerging issues that may impact the agency and population served; and reinforcement of program objectives on a consistent, statewide basis.

As previously mentioned, effective 3/1/04 Kentucky's early intervention program was transferred to the Division of Adult and Child Health Improvement. The Medical Director, Dr. J. William Holmes

continues to provide medical oversight for the CCSHCN's Title V program. Program divisions include: 1) Health and Development; 2) Administrative Service ; and 3) Quality Outcomes Management.*See attached Organization Chart. The division of the Commission's local statewide offices into three distinct regions with Nurse Service Administrators as regional managers was maintained within the Division of Health and Development.

The Commission's Executive Director, Medical Director, and Directors of the Divisions of Administrative Services, Health and Development and Quality and Outcomes are appointed by the Governor, as are members of the Board of Commissioners, and the Hemophilia Advisory Committee. The Commission's Executive Director with approval of the Board of Commissioners appoints members of the Medical Advisory Committee. The primary role of the Board of Commissioners is to provide oversight and approval of the executive director's actions. The Board meets quarterly with the Executive Director and senior management staff to review program status, consult and advise on programmatic concerns, and take voting action as may be required on certain issues or business such as appointments to the Medical staff.

Under the newly reorganized Cabinet for Health and Family Services, the Commission reports to the Undersecretary for Children and Family Services, Eugene H. Foster, ED.D. Additionally, he brings a wealth of experience and expertise in strategic planning, staff development, and community capacity building for systems change. In addition to the Commission, Dr. Foster oversees the Department for Community Based Services (DCBS). DCBS administers an array of income assistance programs, including TANF and Food Stamps; determines eligibility for Medicaid/SCHIP and the Kentucky Physicians Care Program; and is responsible for child and adult protective services, foster care (including medically fragile foster care) and adoption.

D. OTHER MCH CAPACITY

Senior Management

Director - Division of Adult and Child Health Improvement
Ruth Ann Shepherd, M.D., F.A.A.P. was appointed Director of the Division of Adult and Child Health Improvement and will begin her duties on September 1, 2005. Dr. Shepherd received her B.A. in Biology, Pre-med from Asbury College, in Wilmore, KY, graduating magna cum laude and her M.D. degree from the University of Louisville School of Medicine. Dr. Shepherd did her residency in Pediatrics at Methodist Hospital Graduate Medical Center in Indianapolis, Indiana and her Neonatology Fellowship at Medical University of South Carolina in Charleston, SC. Dr. Shepherd has Board Certifications from the American Board of Pediatrics and the American Board of Neonatal-Perinatal Medicine. Dr. Shepherd professional experience includes partner in private practice in Neonatology and General Pediatrics. Most recently, Dr. Shepherd has been Director of Neonatology Services, Pikeville Methodist Hospital, a Regional Level II+/3A Neonatal Intensive Care Unit with Regional Neonatal Transport Service, Infant Apnea Program, Neonatal Developmental Follow-Up Clinic, and Kentucky Early Intervention System 0-3 Intensive Evaluation Team and as Medical Advisor to the Infant Hearing Screening Program. Dr. Shepherd also holds additional clinical and administrative certifications and is a member of numerous professional organizations including a Fellow with the American Academy of Pediatrics since 1984 and the National and Kentucky Perinatal Associations. She has also provided her expertise to leadership roles with the March of Dimes, the Governor's Conference on Infant Mortality, Healthy Start/HANDS Task Force, and the Kentucky Folic Acid Partnership.

Branch Manager, Maternal and Child Health
Leading this branch since September of 2002, Linda Lancaster has been with the DPH since 1988; working with Kentucky's Early Intervention Program (First Steps), Kentucky's Birth Surveillance Registry, State Folic Acid Supplementation Program, Adult Preventive and Arthritis programs. Ms. Lancaster has an Associate Degree in Nursing from the University of Tennessee School of Nursing, a

Bachelor of Science Degree in Health Education from Peabody College at Vanderbilt University and a MPA from Kentucky State University School of Public Administration.

Branch Manager, Nutrition Services
Frances M. Hawkins manages the Nutrition Services Branch. Ms. Hawkins coordinates the Nutrition Services Branch, which administers the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the Adult and Child Health (ACH) Nutrition Program, the Five A Day Program, the Farmers' Market Nutrition Program (FMNP) in collaboration with the Kentucky Department of Agriculture and the Obesity Component of the Centers' for Disease Control Chronic Disease Prevention and Health Promotion Programs Grant. Ms. Hawkins received her early training at Indiana University of Pennsylvania and her Master's degree at the University of Kentucky. She has managed the Nutrition Services Branch since 1996 and is a registered, licensed dietitian.

Branch Manager - Health Care Access Branch
John Hensley has been an employee of Kentucky State Government for over twenty-one years. He began his career with the Department for Education and soon moved to the Cabinet for Families and Children where he worked for sixteen years. Moving up within the Cabinet, he started as a staff member of the Family Service Office and after several years was promoted to the position of Family Sevices Office Supervisor. In 2000, he moved to the Department for Public Health where he was a Program Development and Evaluation Specialist for the Cardiovascular Health Program before transferring to the Health Care Access Branch to administer Kentucky's J-1 Visa Waiver Program. He was promoted to Branch Manager in October of 2003. Mr. Hensley received a degree in Sociology from Morehead State University.

Branch Manager - Chronic Disease Prevention & Control
Curt Rowe has worked in the area of public and private not-for-profit health care endeavors for the past thirty years. Earning his undergraduate degree in business administration at Berea College, he went to on to earn his Master's of Public Health degree at the University of North Carolina. In his professional roles, Mr. Rowe has supervised employees in various departments of private, not-for-profit hospitals, in health promotion and disease prevention initiatives, in grant-funded initiatives, and in numerous appointed work groups.

Branch Manager - Early Childhood Development
Effective August 1, 2005, Joyce Robl will become the Branch Manager of the Early Childhood Development Branch. Ms. Robl brings years of academic and clinical experience in children's issues to this position. Ms. Robl has a BA in Biology from the University of Maryland Baltimore County and a Master's of Science in Human Genetics from the University of Michigan. Board Certified in Genetic Counseling in 1993, Ms. Robl was a member of the University of Kentucky Dept of Pediatric providing genetic counseling services prior to joining the KY Dept for Public Health in 1999 where she has worked in a number of Maternal and Child Health assignments including the KY Birth Surveillance Registry.

Other Key Program Staff

James C. Cecil is the Administrator of the Office of Oral Health for the Commonwealth of Kentucky, under the Health Care Access Branch of Adult and Child Health. Prior to his appointment, Dr. Cecil was a faculty member in the Division of Dental Public Health, Department of Oral Health Science in the College of Dentistry at the University of Kentucky. He has been a faculty member since his return to Kentucky in 1996, where he completed a distinguished career with the United States Navy Dental Corps. His research and service projects relate to access to oral health care where he is actively involved with the development of preventive dental outreach programs that service Appalachia, Central and Western Kentucky. Dr. Cecil received his Doctor of Dental Medicine degree from the University of Kentucky and his Masters in Public Health degree from the School of Public Health at the University of Michigan.

Tracey D. Jewell is the lead maternal and child epidemiologist for the MCH Branch. Ms. Jewell earned

her Master's of Public Health at the University of Alabama Birmingham School of Public Health in 1998. She joined the staff at the DPH in February of 1999 and came to the MCH Branch in January of 2001 to assume her present position.

Julie Franklin is the Client Manager for the Division of Adult and Child Health Improvement (ACHI). Client manager positions were established by the Commonwealth Office of Technology to act as a liaison between the Office of Information Technology (OIT) and program areas within the Cabinet for Health and Family Services (CHFS) in November of 2004. They were created to better serve the information technology needs of the program areas. Ms. Franklin has been employed by the Commonwealth Office of Technology since 1999 prior to joining the staff at CHFS in 2004.

Commission for Children with Special Health Care Needs - Senior Management Staff

Executive Director - Eric Friedlander has been Executive Director of the Commission since June 2000. Mr. Friedlander is a graduate of Antioch College with a B.S. in Economics and has served 16 years in KY state government with experience in administration of health and human service programs. Before coming to Commission, Eric served as manager of Statewide Family Resource and Youth Services Centers Program -- a school based health and human service program designed to remove barriers to children's learning and as manger of the Budget and Policy Branch of the office of Program Support for the Cabinet for Health Services.

Medical Director - J. William Holmes has been medical director at the Commission since November 1993. He has a bachelor's degree in philosophy from Vanderbilt University and an M.D. from the University of Louisville. He has completed training in Pediatrics at the University of Louisville and Neurology/Pediatric Neurology at the University of Kentucky. He was on the faculty of the Departments of Pediatrics and Neurology at UL for 13 years and still holds a clinical appointment. He works with the pediatric specialists throughout the state to assure that the Commission has properly credentialed physicians and dentists delivering services in the Commission clinics. In addition to his consultative and advisory role for Title V/CSHCN services, Dr. Holmes also serves as a reviewer and advisor for First Steps.

Director of the Division of Administrative Services- This position remains unfilled. It was previously reported that responsibility for CYSHCN portion of the Title V MCH Block Grant was assigned to Theresa Glore. Ms. Glore retired effective December 31, 2004. Responsibility for the CYSHCN portion of the Title V MCH Block Grant was assigned to Susan Cole effective April 1, 2005. Ms Cole earned her B.A. from Knox College, Galesburg IL. She was admitted to the Kentucky Society of Certified Public Accountants in August 1995.

Director of the Division of Quality and Outcomes - Anja Peersen has been a Division Director at the Commission since February of 2000. Ms Peersen resigned from the Commission effective December 31, 2004. Her position remains unfilled.

Statewide Staff (including Family Professionals) The Commission has a designated Information Systems (IS) Branch with a manager and three key personnel and one contract consultant who are working to develop the Computer Utilization Project (CUP), a custom, web-based data management and warehouse system. The Cabinet has notified us of the intent to centralize IT services. Commission IT staff assigned to CUP was centralized under the Cabinet. The IT staff has been allowed to remain on-site at the Commission and basically report to Commission Management. We believe the Cabinet is planning to concentrate their efforts to supporting applications that are unique to the Cabinet (TWIST, KAMES, EPHRS, CUP, etc.). No further changes in IT administration are anticipated for the foreseeable future.

Our parent/education liaison, Linda Miller, remains on staff. Ms. Miller is focusing on building partnerships with the state's various family-professional organizations and with the Dept. for Education, Division of Exceptional Children to enhance transitions planning and services for cshcn

E. STATE AGENCY COORDINATION

Collaboration: Adult and Child Health Improvement / Commission for Children with Special Health Care Needs

The Directors of these two organizations remain in close contact by telephone and e-mail (and blackberries) despite the physical distance between the agencies. They, as well as the Title V Administrator and the Director of Administrative Services, maintain excellent and close working relationships; continually building bridges between the two agencies.

Cooperative ventures between ACHI and the Commission include: Folic Acid Supplementation, Kentucky Birth Surveillance Registry, State Systems Development Initiative (SSDI grant), fluoride varnish and screening. A representative from ACHI is an ex-offico member of the Commission Board.

Collaboration - Adult and Child Health Improvement / Local Health Departments

The Department for Public Health and local health departments are facing new challenges in service delivery. There are three health care delivery system changes that are currently impacting local health departments;
1) Medicaid cost-based reimbursement phase out; 2) private providers providing medical homes via Medicaid Managed Care and the KenPAC physician case management program and finally; 3) the reduction in the number of Medicaid patients so that those local health departments still providing direct clinical services have fewer opportunities to generate reimbursement from Medicaid.

In general, children and pregnant women in Kentucky are well supported through the KCHIP and Medicaid insurance systems. The service gap identified is for the adult males and non-pregnant females as well as for undocumented immigrants of all ages. And it is the latter group whose increasing numbers stretch the safety net system. Many local health departments are using Title V funding to provide prenatal services to this population.

Collaboration: Adult and Child Health Improvement / CCSHCN / Department for Medicaid Services

The Division for Adult and Child Health Improvement has a long history of cooperation with the Department for Medicaid Services. Kentucky's CHIP program (KCHIP) is also coordinated through this department as is KenPAC, Kentucky's Managed Care Program.

KCHIP: Kentucky implemented the KCHIP program in multiple phases. The first phase began July 1, 1998, as an extension of Medicaid coverage to children between the ages of 14 to 18 who were in families at or below 100% of the Federal Poverty Level (FPL). The second phase of KCHIP began on July 1, 1999. Medicaid was expanded to cover eligible children from age one through 18 years who did not already have health insurance and whose family income fell at or below 150% FPL. The third phase began in November 1999 as separate insurance program. This phase covers children whose family incomes are 151% FPL and up to 200%. The separate insurance program offers the same benefits as Medicaid, except for non-emergency transportation and Early Periodic Screening Diagnosis and Treatment (EPSDT) special services.

Eligibility is determined by the Department for Community Based Services (DCBS). KCHIP children use the same health care providers as Medicaid and are served through the same service delivery systems as Medicaid.

KCHIP members enrolled are required to select a Primary Care Physician (PC). PCPs or Primary Care Case Managers are responsible for the coordination of medical services for children enrolled in KCHIP. The purpose for these medical homes is to provide each child with a health care professional who understands the unique needs of the child.

KCHIP enrollment data as of March 2001 - 54,183 - Cumulative Enrollment Data - 77,532
KCHIP enrollment data as of March 2002 - 51,368 - Cumulative Enrollment Data - 133,635
KCHIP enrollment data as of March 2003 - 50,531 - Cumulative Enrollment Data - 161,959
KCHIP enrollment data as of March 2004 - 48,776 - Cumulative Enrollment Data - 187,126

*Phase I children ages 14 - 18 up to 100% FPL are now covered by Medicaid's Title XIX - basically enrollment has stayed the same.

KenPac - Implemented in 1985, the Kentucky Patient Access and Care (KenPAC) Program is a primary care case management program that increases access to primary and preventive health services and coordinates other Medicaid covered health care and related services for Medicaid members eligible to participate in the program. A pediatrician, internist, family doctor, general practitioner, OB/GYN, rural health clinic, primary care center or nurse practitioner acts as the primary care provider (PCP) for Medicaid members enrolled in KenPAC. Kentuckians who receive financial assistance through the Kentucky Transitional Assistance Program (K-TAP), which was formerly Aid to Families with Dependent Children (AFDC) and adults aged 19 and older who receive Supplemental Security Income (SSI), are enrolled in the KenPAC program.

In the month of March 2004, KenPAC served approximately 346,115 enrollees (adults and children) in 104 counties.

In 2001, the KenPAC program added a care coordination support function. The program is staffed entirely by experienced registered nurses that are located around the Commonwealth in areas with high Medicaid population densities. The KenPac care coordinators serve as a liaison between Medicaid and the KenPAC providers. Additionally, on a case-by-case basis, these nurses are available to assist with heath care service coordination for KenPAC recipients with unique health problems.

In April, 2003 KenPAC Care Coordination began two six month pilot projects targeting members with large claims, for treatment of congestive heart failure and prescription drugs. Working closely with the member's KenPAC primary care provider, the pilot projects are intended to study a sample population with the intent to reduce costs and to improve the quality of health care.

Memorandums of Agreement (MOA's) - ACHI and Medicaid:

The Division of Adult and Child Health Improvement, as the state Title V agent, has a long history of working cooperatively with the Department for Medicaid Services. This relationship continues through several Interagency Agreements that are renewed annually and are listed below:

Preventive health services delivered to Medicaid recipients by local health departments and reimbursed by the Department for Medicaid Services.

Medicaid reimbursement for early intervention services for infants and toddlers who are determined eligible for First Steps, Kentucky's Early Intervention System, authorized by the Individuals with Disabilities Education Act.

Medicaid coverage for targeted case management services to pregnant women, parents and children served by HANDS, the Health Access Nurturing and Development Services Program.

Medicaid Services Presumptive Eligibility Program for Pregnant Women is in place and will allow pregnant women to receive prenatal care through Medicaid for up to 90 days while their eligibility for full Medicaid benefits is determined.

An agreement is in place between the Department for Public Health, Department for Medicaid Services and Department for Community Based Services. This agreement provides Medicaid reimbursement for targeted case management for Medicaid patients (including children in custody or

at risk of being in custody of the state and adults in need of protective services) and for rehabilitative services for Medicaid-eligible children in custody or at risk of being in custody of the state.

The Department for Public Health, Department for Medicaid Services, Department for Community Based Services and Department for Mental Health/Mental Retardation Services also have an interagency agreement for provision of community-based mental health services to children who are in custody or under supervision of the state, or at risk of being in custody of the state; and have just been discharged from a psychiatric facility or at risk of institutionalization in a psychiatric facility.

Memorandums of Agreement (MOA's) - CCSHCN and Medicaid:

In addition to the MOA with ACHI, the Commission also maintains a separate MOA with the Department for Medicaid Services to enable the Commission to provide therapeutic remedial services for applicable Medicaid eligible children enrolled for Title V/CSHCN services This agreement references the applicable federal and state statutes or regulations and assure that services are provided in accordance with the Title XIX State Plan and EPSDT special services as required by OBRA 89. This MOA is renewed annually.

Collaboration: Adult and Child Health Improvement / Department for Mental Health and Mental Retardation

As part of the KIDS NOW Early Childhood Development Initiative, the Kentucky Division of Mental Health and Substance Abuse, Department for Mental Health and Mental Retardation, is working in partnership with the Department for Public Health in a statewide effort aimed at increasing the health of all Kentucky babies by decreasing the use of alcohol, tobacco, and other drugs during pregnancy. To date, 80 health departments across the state have a Memorandum of Understanding (MOU) with a regional Comp Care Center to address prevention and treatment of substance abuse in pregnant women. Eleven (11) of the forty (40) health departments who do not have a MOU with the Comp Care Centers are working in partnership to develop a MOU to address this important issue.

Health departments have screen pregnant women for alcohol, tobacco, and other drugs using the 4 P's Plus research-based screening tool. By using this tool, women who fall into lower level risk groups can be referred for prevention services, while those in the high risk category can be referred for a fuller substance abuse assessment to the Comp Care system. As a result of this collaboration, thousands of pregnant women struggling with substance abuse issues in Kentucky are being reached. The Comp Care Centers working under the KIDS NOW Early Childhood Development Initiative provide substance abuse prevention and /or treatment services to pregnant women.

The Maternal and Child Health Branch has a collaborative agreement in place for Suicide Prevention Services and MCH staff serve on the Suicide Prevention Advisory Group. MHMR staff serve on the State Child Fatality Review Team. In September 2005 the Kentucky Department for Mental Health and Mental Retardation and the Kentucky Suicide Prevention Group (KSPG) are sponsoring a 2 day workshop on Suicide Prevention. For more information you may visit the website at http://mhmr.ky.gov/mhsas/suicidepreventiongroup.asp

Additionally, a collaborative agreement is in place between these agencies to provide mental health services for childbirth to five, primarily in the child care setting (Healthy Start in Childcare)and the Early Childhood Mental Health Program.

Addressing the problem of substance abuse by Kentucky citizens is one of Governor Fletcher's primary health initiatives. The ability of the Department for Public Health to partner with substance abuse professionals has been enhanced with the reorganization of state government including the transfer of the Substance Abuse Prevention Branch to Adult and Child Health Improvement in June 2004. The Substance Abuse Prevention team is located in the Chronic Disease Branch of ACHI but has been working with many of the MCH programs including the Prenatal program, Family Planning, Well Child and the Kentucky Birth Surveillance Registry.

In October 2004, the Department for Public Health was awarded a five to seven year, 11.5 million dollar (2.3 million per year) Strategic Preventiove Framework State Incentive Grant (SPF-SIG) from the US Department of Health and Human Services. State Strategic Prevention Framework State Incentive Grant

In October 2004, the Department for Public Health was awarded a 5 to 7 year, $11.5 million Strategic Prevention Framework State Incentive Grant (SPF-SIG) from the US Department of Health and Human Services, Substance Abuse & Mental Health Services Administration (SAMHSA). The Strategic Prevention Framework is a process designed to increase the effectiveness of substance abuse prevention on the state and local level through collaborative interagency planning. To this end, Kentucky's initative will bring together 6 Key Partner Agencies (the Department for Public Health, the Department of Education, the Department for Juvenile Justice, the Department for Mental Health and Mental Retardation Services, the Department of Family Resources and Youth Services and the Governor's Highway Traffic Safety Initiative) to draft a statewide strategic plan and to work through their local agencies in targeted communities to implement research based prevention programs and strategies. Each of the Key Partner Agencies will create and implement home teams to help with implementation. The Framework is a five-step process to expand, extend, and more fully integrate the state substance abuse prevention infrastructure.

Collaboration: Adult and Child Health Improvement / Other State Agencies

In an attempt to assure health access, interventions and positive outcomes, the Division of ACHI participates in a high degree of coordination and collaboration with other state human service and educational agencies.

-ACHI/Department of Education: In 2003 Kentucky was selected as one of eighteen states to receive a Centers for Disease Prevention & Control - Division of Adolescent School Health (CDC-DASH) Coordinated School Health (CSH) Infrastructure grant. The Kentucky Department of Education (KDE) and the Kentucky Department for Public Health (KDPH) partner together to develop, implement and evaluate a coordinated school health program at the state level. The grant award is for $ 415,000 with $ 100,000 allocated to the Department for Public Health to fund a full-time coordinator, travel and supplies. Additionally, 3 FTE positions have been established within the Department for Education to support coordinated school health activities.

Through this state infrastructure, schools and school districts, with assistance from local health departments and other partners, will create and/or strengthen local CSH Programs. CSH consists of an eight-component national model that recognizes how health, wellness, environment and learning are related. This model is an organized set of policies, procedures, and activities designed to promote and sustain the health of students and staff. The eight components include health education, physical education, health services, nutrition services, counseling/psychological services/social services, health school environment, health promotion for staff and family/community involvement. Many other programs within the Division are linked with this project, specifically through a CSH Interagency committee, which includes representatives from Tobacco, Substance Abuse Prevention, Asthma, HIV/AIDS, Well-Child, Abstinence Education, Family Planning, Diabetes, Nutrition, Obesity, Cardiovascular Health and Physical Activity.

A coordinated approach to school health improves students' health and their capacity to learn through the support of families, schools, and communities united efforts. A very central theme of CSH is keeping students in school, maintaining health over time, and reinforcing positive healthy behaviors throughout the school day. This provides a clear understanding for the student that good health and learning go hand in hand. CSH offers students the information and skills they need to make good choices in life. More information about this program nationally can be found at the following website: http://www.cdc.gov/nccdphp/dash/SHI/index.htm

The KY Dept of Education has coordinates the KIDS NOW! Initiatives with DPH, CCHSCN, MHMR,

Medicaid, etc.

Another key partner, Foundation for a Healthy Kentucky (http://www.healthyky.org/), has supported coordinated school-based projects through funding of school grants to expand, replicate or enhance Coordinated School Health Programs in Kentucky communities. Approximately $800,000 for school grants and evaluation were allocated in 2004-05 and funding will continue in 2005-06.

ACHI continues to serve as a member of the Kentucky Developmental Disabilities Council.

Many other coordinated school-based activities are underway in Kentucky. Information about specific activities are integrated throughout the narrative; particularly under the area of nutrition and physical activity.

Collaboration: CCHSCN/Other State Agencies

Besides key partnerships with ACH and Medicaid, the Commission for Children with Special Health Care Needs has historically maintained and built new partnerships to enhance the system of care for CYSHCN. In the past year the Commission has worked with the Cabinet for Families and Children to identify Title V/CSHCN enrollees who are residing in foster care and to share program information that will assure coordination of services for children in foster care.

The Commission maintains a strong relationship with the KY Department of Education, with the Executive Director serving on the State Advisory Panel for Exceptional Students. A MOU between CCSHCN and DOE calls for exploring avenues to link transition related data sets to measure and monitor student progress. The state agency for protection & advocacy, developmental disabilities council, and the university center for excellence in addition to the departments for community based services, vocational rehabilitation, and employment services are partnering with the Commission in the Family Support 360 Planning Grant. The Commission serves on the Department for Mental Health's Co-Occurring Disorders Workgroup, which is studying the need for appropriate behavioral supports for the growing number of CYSHCN presenting with dual diagnosis. A representative of the Commission serves on the state early intervention Interagency Coordinating Council.The Commission also partners extensively with the two state medical schools and their teaching hosptials for specialty care for CYSHCN enrolled in the Title V medical services program.

Collaboration: Adult and Child Health Improvement / Tertiary Centers

The Division of Adult and Child Health Improvement has contracts with both the University of Louisville and the University of Kentucky for tertiary activities in the areas of genetic services, neonatal care, metabolic services, sickle cell and developmental services. The tertiary centers also provide invaluable consultation and educational offerings to ACHI and hundreds of providers across the state.

-University of Louisville

Community Development Evaluation Services: Community Development Evaluation Services are provided to the Western half of Kentucky through the U of L Child Evaluation Center. They provide 325 multi-disciplinary tertiary evaluations and 260 single-discipline evaluations to children birth to sixteen to determine complex developmental disorders, program eligibility and service recommendations as well as support and educational services to families and health providers. Evaluations are done both at the University's Child Evaluation Center and through a series of traveling clinics across the western half of the state.

High Risk Infant Follow-up Project: The Neonatal Follow-Up Clinic provides developmental screening assessments for high-risk and premature infants for the Western half of Kentucky. The staff provides center based multi-disciplinary neuro-developmental screening to interpret diagnoses to families; identify intervention needs, and initiate specialty referrals. These evaluations are done at both the

University's Neonatal Clinic in Louisville and at regional neuro-developmental screening clinics housed in western Kentucky hospitals. In addition, the staff provides technical assistance and education to Pediatricians and other health care professionals throughout the state on how to manage the needs of the premature, high-risk infant they are serving in their local communities.

Other Contracts Impacting Maternal and Child Health with the University of Louisville: These include metabolic screening and case management for children with identified conditions; genetics referral and outreach, maternal mortality, nutrition education for providers of high-risk women; physician and public health nurse continuing education and oral health survey implementation and data analysis.

-University of Kentucky (Lexington)

Infant Intensive Care Project: The Infant Care Project provides 175 multi-disciplinary developmental assessments to acutely ill children to interpret findings to families; identify intervention needs and to initiate specialty referrals. These services are provided to children admitted to the NICU.

The Department for Public Health has an active collaboration with the Kentucky Dental Association, the Kentucky Dental Hygiene Association, the Kentucky Dental Health Coalition, the dental schools at the University of Kentucky and the University of Louisville, other state and federal agencies.

F. HEALTH SYSTEMS CAPACITY INDICATORS

Health Systems Capacity Indicator # 01
The rate of children hospitalized for asthma (per 10,000 children less than five years of age).

Data for this measure improved significantly since FY1998. A new vendor for hospital billing data (CompData) was awarded the state contract in 2000. Data from FY1999 is far more accurate than in previous years when only a few of the larger Kentucky hospitals reported inpatient cases. Kentucky has incomplete data for this measure because no emergency room data is collected by the Department for Public Health; only inpatient data is available at present.

Identified asthma cases for 2001 increased from the previous year. 2000 rates show 44.9 per 10,000 while 2001 increased to 60.8 per 10,000. Inpatient data is the only data available and shows a portion of the cases. Data for FY02 remained the same, with a rate of 60.8 per 10,000 children hospitalized for asthma. A great deal of work in the area of asthma has recently occured within the Department for Public Health. Data in FY03 shows a significant increase in the asthma hospitalization was shown with the rate of 69.2. Because of the rising rates, a great deal of work in the area of asthma has recently occurred within the Department for Public Health.

The Chronic Disease Prevention and Control Branch, along with other important partners in Kentucky, applied to the CDC for a Public Health Prevention Specialist, to be located within the branch and to carry out activities specifically related to asthma. The Prevention Specialist was assigned to work in Kentucky August 2003 to September 2005. Additionally, the Kentucky Asthma Partnership was established to coordinate asthma activities across Kentucky. The four primary partners are the American Lung Association of Kentucky, the University of Kentucky, the University of Louisville, and the Kentucky Department for Public Health. Other members include healthcare systems, clinicians, local health departments, local asthma coalitions, Medicaid, KDE, environmental health, and citizens' advocacy groups.

The Chronic Disease Prevention and Control Branch submitted a grant application to CDC for funding to build an asthma program, to develop a surveillance system for asthma, and to develop a statewide asthma strategic plan. Additionally, the Kentucky Asthma Partnership developed a burden document to describe asthma in Kentucky and provide recommendations for next steps to address asthma in Kentucky.

Activities in 2006 include establishing an asthma program at the Kentucky Department for Public

Health, developing a statewide surveillance system, and developing a statewide asthma plan.

Health System Capacity Indicator # 02*
The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen.

Ninety-five percent of Medicaid enrollees in Kentucky received at least one initial periodic screen in 1999, in 2000, 81.1% and in 2002, 91% received EPSDT screenings. This indicator declined to 81.3% in 2002* and declined again in 2003 to 80.3%.

* During 2002 the mail-in recertification form was replaced by face-to face interviews for recertification, which resulted in a lower number of recipients applying for benefits. Numbers are beginning to stablize in 2003 as people adapt to the new system.

Health System Capacity Indicator #03

The percent of State Children's Health Insurance Program (CHIP) enrollees whose age is less than one year who received at least one periodic screen.

Again, a substantial increase has been seen between 2000 and 2001. Seventy-nine percent of CHIP enrollees whose age is less than one year have received at least one periodic screen as compared with 40.9% in 2000. In 2002, however, a decrease was seen in this measure, as it dropped to 61%. In 2003, numbers stabilized and increased to 83.8%.

During 2002 the mail-in recertification form was replaced by face-to face interviews for recertification, which resulted in a lower number of recipients applying for CHIP benefits. Numbers are beginning to stabilize in 2003 as people adapt to the new system.

Health System Capacity Indicator #04

The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

Kentucky's women are receiving adequate prenatal care as based on calculations using the Kotelchuck index. In 2000, 80.6% of women of childbearing age in Kentucky received adequate prenatal care and in 2001, this number rose slightly to 80.8%. Data for this measure continues to increase steadily with 82% of women receiving adequate prenatal care, based upon the Kotelchuck Index in 2003.

Health System Capacity Indicator #05

Comparison of health system capacity indicators for Medicaid, non-Medicaid, and for all MCH populations in the State. Data for this Health System Capacity Indicator is not available - linkage not achieved as of summer 2005.

Health System Capacity Indicator #06

Medicaid/Chip Eligibility Levels (Form 18). Please see data included within the HSCI section for levels for children and pregnant women.

Health System Capacity Indicator #07*

The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

Total eligibles for EPSDT services of this age group remained fairly steady during the 2000 - 2003 period. Indicator totals increased slightly each year from 41% in 2000 to 46% in 2003. In 2004, however, a decline was seen to 22%. Planners will be exploring this drop but feel that a part of the reason is that during 2002, the mail-in recertification form was replaced by face-to face interviews for recertification, which resulted in a lower number of recipients applying for CHIP benefits. It is hoped that numbers are beginning to stabilize as people adapt to the new system.

Health System Capacity Indicator #08

The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program.

Between October 1, 2001 and September 30, 2002 the Commission served a total of 4,190 SSI eligible children. This represents non-duplicated children receiving services in the Disabled Children's Program, the SSI/Children's Support Services Program, or the Title V/CSHCN medical program. Currently the Commission is unable to report valid information on services to SSI eligible children enrolled in First Steps.

For many years, the Commission administered the SSI/Disabled Children's Program (DCP) that provided a broad array of early intervention support and medically necessary services to SSI recipient children aged birth through three. DCP was closed effective June 30, 2002 and the Commission had planned to continue providing limited medical support services beyond those that could be provided under Medicaid or other resources for SSI eligible children ages birth to 16 under a new program the SSI/Children's Support Services Program (SSI/CSS). Although SSI/CSS was established in the fall of 2002 and a few applicants received services through May 2003, the increasing budgetary constraints lead the Commission to make the difficult decision to limit activities on behalf of SSI eligible children to only those services that are mandated for state Title V/CSHCN programs.

Effective July 1, 2003, the Commission no longer offered separate programming for children receiving SSI benefits. Applications for services under the SSI/ Children's Support Services Program (formerly SSI/Disabled Children's Program) were not be accepted after May 30, 2003. The Commission will continue to document services to SSI eligible children and youth who qualify for services in the Title V/Children with Special Health Care Needs medical program and will work with the data repository for First Steps children at the University of Louisville to strengthen capacity to track SSI eligibility of children receiving FS early intervention services.

The Commission will also continue to partner with the Social Security Administration and Disability Determinations Services to provide outreach and referral information to families who apply for SSI disability benefits for children or youth under age 16. Families of young SSI recipients and youth under age 16 who receive SSI benefits may contact the Commission at 1-800-232-1160 (or by email from the agency website: CCSHCHWebPage@mail.state.ky.us)for assistance in locating resources to meet medical or rehabilitative needs that are not covered under Title XIX (Medicaid).

The Commission served 7.66% (1,699) of children and youth under the age of 16 who receive SSI benefits in Kentucky. This number is significantly lower than in previous years due to the discontinuation (as a result of state revenue shortages) of the Disabled Children's Program that provided additional services to this population.

Health System Capacity Indicator #09 A

The ability of States to assure that the Maternal and Child Health program and Title V agency have access to policy and program relevant information and data.

The Division of Adult and Child Health Improvement and the Commission for Children with Special Health Care Needs will both address data capacity issues within this section.

Division of Adult and Child Health Improvement/Maternal and Child Health Branch:

Currently, the MCH Branch has the ability to access many types of maternal and child health data through the work of our lead MCH Epidemiologist, Tracey Jewell, MPH. Ms. Jewell works with MCH Branch staff, analyzing vital statistics data, service data (through the Patient Services Report System -- local health department service/payment data), KBSR data and FPAR data and other information as needed.

Vital Statistics live birth certificates are linked on an annual basis to death certificates. The Maternal and Child Health Epidemiologist has direct access to all electronic files regarding vital events for Kentucky. The birth and death records are linked through the process of running a SAS program that links death certificates to birth certificates based on pre-defined variables and criteria. This process creates a temporary SAS dataset from which detailed analysis can be performed on linked records.

Using the State System Development Initiative Grant (SSDI), linkages will begin for birth and death vital records in 2004. The Kentucky Department for Public Health is partnering with the University of Louisville School of Public Health and Information Sciences to examine current needs for linkages and to link data sets identified by program staff. The University of Louisville will also assist CHFS IT Staff in a technical assessment in order to determine capacity to be used for the MCH SSDI grant for linkages described above. While beginning with birth and death records, other systems targeted for future linkages include Medicaid eligibles and Newborn Screening records (Metabolic and Hearing).

In 2000, hospital discharge survey data was available through the Kentucky Department for Public Health's Health Policy Branch. UNISYS had been the vendor for the prior contract period but lost the contract to CompData in 2000. The relationship with CompData during the early period of the new contract has been excellent with more complete and timely data submission.

The Kentucky Birth Surveillance System is fully functional. Data abstracted from 1998 - 2002 is published on the DPH website at http://chfs.ky.gov/dph/ach/kbsr.htm

Currently Kentucky does not provide a new mothers survey such as PRAMS but will be submitting an application for PRAMS funding in November 2005. Some information regarding pregnancy is collected using the annual BRFSS.
Instead, information regarding intendedness of pregnancy has been collected the last two years utilizing state-added questions on the BRFSS survey. Data will be used to analyze the percentage of pregnancies in KY that were unintended and assess populatioins at risk for unintended pregnancies so that program planning and implementation can be targeted to appropriate populations. Data will also be used in the Federal Title X Family Planning Block Grant application.

Prevelance data required includes but is not limited to: intendedness of pregnancy among women of childbearing age, methods used to prevent pregnancy and type used, and if no contraception used, reasons why. This data will be used in the monitoring of performance measures contained within the Title X grant as well as tracking trends over time.

The following questions were asked ONLY to women aged 18-44.

If pregnant now ("Yes" to core Q10.11), go to Question 2.

1. Have you been pregnant in the last five years?
1. Yes
2. No -- Go to next module
7. Don't know/Not sure
9. Refused

2. Thinking back to just before you got pregnant with your most recent pregnancy, how did you feel

about becoming pregnant? Check only ONE answer.
1. You wanted to be pregnant sooner
2. You wanted to be pregnant later
3. You wanted to be pregnant then
4. You didn't want to be pregnant then or any time in the future
7. Don't know/Not sure
9. Refused

3. When you got pregnant with your new baby, were you or your husband or partner doing anything to keep from getting pregnant? (Some things people do to keep from getting pregnant include not having sex at certain times (rhythm), and using birth control methods such as the pill, Norplant?, shots (Depo-Provera?), contraceptive patch, condoms, diaphragm, foam, IUD, having their tubes tied, or their partner having a vasectomy.)
1. Yes -- Go to question 5
2. No
7. Don't know/Not sure
9. Refused

4. What was your or your husband or partner's main reason for not doing anything to keep from getting pregnant?
1. You wanted to get pregnant
2. You didn't want to use birth control
3. Your husband or partner didn't want to use birth control
4. You thought you could not get pregnant
5. You can't pay for birth control
7. Don't know/Not sure
8. Other
9. Refused

If currently pregnant, then go to next BRFSS module.
5. After your new baby was born, did a doctor, nurse, or other health care professional talk with you about using birth control?
1. Yes
2. No
7. Don't know/Not sure
9. Refused

The following information was collected from self-reported responses from women aged 18-44 who reported being pregnant within the past five years:

1.) Thinking back to your last pregnancy, how did you feel about being pregnant?
14.4% wanted to be pregnant sooner
17.8% wanted to be pregnant later
53.6% wanted to be pregnant then
14.3% did not want to be pregnant then or anytime in the future

2.) 17.3% reported using birth control before last pregnancy
82.8% reported not using birth control before last pregnancy

3.) What were your reasons for not using birth control before your last pregnancy?
79.6% wanted the pregnancy
5% did not want to use birth control

1.4% said their husband/partner did not want them to use birth control
8.4% thought they could not get pregnant
1% said they could not pay for birth control
5% some other reason

4.) After your last pregnancy, did a doctor or health professional discuss using birth control with you?
80.6% yes
19.4% no

Health Systems Capacity Measures # 09B and 09C - Data Capacity

Division of Adult and Child Health:

The Youth Behavioral Risk Survey is coordinated by the Kentucky Department of Education in cooperation with the Department for Public Health. Participation for the YRBS increased in 2003 and the resulting data was weighted and will be published. For more information about Kentucky's data, please see the CDC website at: http://www.cdc.gov/HealthyYouth/yrbs/

The ability of States to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month.

This data is based on the Youth Risk Behavioral Survey, completed every other year in Kentucky. In 1997, 47 percent of those surveyed reported using tobacco products during the past month. In 1999, a slight increase to 48.1% was reported. In 2003, 33% of participants reported smoking cigarettes and 14% reported using smokeless tobacco during the past month.

To meet this new health challenge, The KDPH through the Tobacco Use Prevention and Cessation Program and the Oral Health Program has developed the Kentucky Quit Spit Program. The Kentucky Quit Spit Program provides spit tobacco prevention education and cessation information to each of Kentucky's Local Health Departments, Family Resource and Youth Services Center's, and Regional Prevention Centers that make up almost 500 public health agencies in the Commonwealth. This design has enhanced the existing local coalitions effectiveness in helping meet our statewide goals.

The Oral Cancer Self Screening Kit Project is the newest health promotion initiative of the Kentucky Quit Spit Program. The Oral Cancer Self Screening Kit Project focuses on meeting the Healthy Kentuckians 2010 Objectives for oral cancer reduction by using the recommended implementation strategies. The Oral Cancer Self Screening Kit Project long-term objectives are to increase the public's awareness, knowledge, and understanding of oral cancer prevention, increase oral cancer exams, and access to timely diagnosis and treatment as needed.

The Kentucky WIC Program has participated in the Pediatric Nutrition Surveillance System (PedNSS) for 30 years. Data on birthweight, short stature, underweight, overweight and anemia is entered into the system for each child that is certified for the Program. This data is collected by the Patient Services Reporting System (PSRS), identified by clinic site and then submitted to the Centers for Disease Control and Prevention (CDC) for analysis. Reports are produced that summarize the data on a nationwide, statewide and clinic basis. The reports are sent to each appropriate WIC Coordinator. The Program is currently working with CDC to transmit the data electronically and receive the data back electronically. This will result in a shorter turnaround time for the data being returned to the clinic.

Commission for Children with Special Health Care Needs:

The Commission continued development of a custom data system Computer Utilization Project (CUP). To maintain confidentiality of protected health information in compliance with the Health Insurance Portability and Accountability Act (HIPAA), identifying information has been encrypted for electronic transportation and security profiles established to provide access only to authorized

individuals. A system audit trail monitors access to information.

CUP features completed during 2002 included the transfer and expansion of our patient encounter system to track patient clinic and non-clinic services, expansion of the social history section to include additional information about education and English fluency, and complete merger of the Hemophilia database into CUP. We began work on a new transitions component that includes a checklist of age appropriate skills that care-coordinators can use to electronically chart the transition accomplishments of individual c/yschn while tracking the overall progress of our population. The checklist is based on the age of the child and will display a list of recommended topics of discussion to the care coordination team. (Another enchancement to CUP during 2002 is a tracking feature for in house and outside appointments.) The Commission's data system has had improvements both in quality and capacity during the past few years thereby allowing us to do meaningful comparisons horizontally and longitudinally regarding the young people in our system and the services provided to them.
The Commission's data system has had improvements both in quality and capacity. While we are confident that CUP provides vital information about the services we provide, transition objectives, both met and unmet, the socioeconomic status of our families and much more, we recognize the importance of periodically evaluating the system as a whole. As other statewide data collection are introduced, systems that will include CUP and UNHS data, and as we explore other opportunities for population based public health practice the Commission feels an increased responsibility for ensuring that data collection is both complete and accurate.

Funds allocated to the SSDI grant to integrate the universal newborn hearing screening (UNHS) database into CUP will be used to support the linkage between UNHS data and birth records. The development of this capacity is a priority so that we are prepared for the time when KDPH (which administers vital records) and the Cabinet are ready to proceed with the data linkage.

The UNHS system has been fully integrated into CUP. The Commission planned to pilot a system enhancement that would have allowed web-based entry of the Hearing Screening Report Form by the birthing hospitals. However, this enhanced capability has been postponed at the request of CHFS until another enhancement, the new electronic reporting system; Electronic Personal Health Record System (EPHRS) has been installed in Kentucky's hospitals. Plans are currently underway to ensure that UNHS & CUP are fully integrated into EPHRS.

A longer-term goal, but no less important, is the development of web-based reporting functions for audiology providers to notify the Commission when infants receive the recommended diagnostic follow-up evaluation.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

Background and Overview
During the 2000 State Legislative Session, a radical new program called "KIDS NOW!" was introduced.
"KIDS NOW!" is a comprehensive plan that addresses issues for children from the prenatal period (folic acid supplementation) to birth (home visitation and newborn hearing screening) to the time that they attend childcare.

This program added $55 million new dollars to programs centered on children in Kentucky, and in excess of $30 million dollars was allocated specifically for programs dealing with maternal and child health. Funded through the national Master Tobacco Settlement, Kentucky's legislature passed a bill that allowed 25% of this funding to be directed to children and families; thereby assuring significant and ongoing support for this population. Outcome Measures for KIDS NOW! are many of the current MCH Block Grant Performance Measures, including early entry into prenatal care, immunization status, low birthweight, births to teens and hearing screening.

Evidence-based data analysis is an integral part of Kentucky's MCH program evaluation process, and the Title V Block Grant National and State Performance Measures are critical to that process. A concerted effort was made to provide detailed program information for each activity that addresses a national or state performance measure.

Both the Commission for Children with Special Health Care Needs and the Department for Public Health welcome questions from readers. Contact information for the main offices of both agencies are listed below. Upon receipt of your call, you will be referred to the appropriate program person.

Kentucky Department for Public Health, Division of Adult and Child Health Improvement 502-564-4830

Kentucky Commission for Children with Special Health Care Needs 502-595-4459

B. STATE PRIORITIES

The Division of Adult and Child Health Improvement and the Commission for Children with Special Health Care Needs will discuss the identification of their priorities separately within this section.

Division of Adult and Child Health Improvement - Ongoing Priorities

Kentucky's State MCH Priorities are many and broad in scope but all focus on improving the health and well being of Kentucky's population. Kentucky faces numerous health challenges over the next decade. Obesity, smoking (prenatally and throughout the population), diabetes, asthma, low birth weight and prematurity, congenital anomalies, the ratio between white and black infant mortality, access to care and child safety are all listed as top maternal and child health issues. Issues like oral health, asthma, childhood lead poisoning prevention, injury prevention and mental health for our youngest citizens are new statewide programs that Kentucky is currently addressing aggressively.

Governor Fletcher pledged during his campaign for governor that he would be dedicated to the health needs of Kentuckians and encourage preventive measures be taken. The Get Healthy Kentucky! Board will gather public input and develop a plan on how Kentucky should go about meeting goals set in the Healthy Kentuckians 2010 report - a report on the state's health needs that includes reduced smoking, reduced use of illegal drugs, increased immunizations, increased access to dental care and improved pre-natal care.

Secretary of the Cabinet for Health and Family Services, Dr. James Holsinger will serve as Chairman

of the sixteen member Get Healthy Kentucky! Board and First Lady Glenna Fletcher will serve as Special Advisor. The Get Healthy Kentucky! Board was created to address the health issues facing citizens across the Commonwealth.

"Kentucky has a number of serious health issues that we must confront," stated Governor Fletcher. "We must start addressing our health issues to help move Kentucky forward."

"Kentucky ranks low in many health indicators and we want to work to improve our rankings," said First Lady Glenna Fletcher. "More importantly, we want to develop and implement ideas to improve the health status of our fellow citizens so they can lead longer, more productive lives."

The board will serve as the guiding force in pulling together several health and wellness efforts currently underway in the state into a stronger and more coordinated effort. The Cabinet for Health and Family Services will provide support and staffing to the Get Healthy Kentucky! Board.

The Department for Public Health has been actively involved in Governor Ernie Fletcher's Get Healthy! Kentucky Initiatives. Staff have presented information at Board meetings and have been heavily involved in the development of the Worksite Wellness campaign that is currently underway in the Cabinet for Health and Family Services. The campaign has highlighted physical activity and is now focused on increasing fruit and vegetable consumption through the 5 A Day program.

Secretary James W. Holsinger Jr., M.D. appointed 22 employees to the Cabinet for Health and Family Services Wellness Committee on Wednesday. The group is charged with creating a climate that fosters better wellness for cabinet employees.

"This is part of the global effort undertaken through Governor Fletcher's Get Healthy Kentucky! initiative to positively impact the health of all Kentuckians and, in this case, cabinet employees," said Secretary Holsinger. "The focus of this committee demonstrates our commitment to improving health for our entire state. We hope this effort will help stimulate the people in our cabinet to reduce risk factors and make positive lifestyle choices."

The Wellness Committee will serve in an advisory role, reporting to Secretary Holsinger on a regular basis. A full-time Wellness Coordinator for the entire cabinet, to be based in the Department for Public Health as part of a federal grant, will be hired soon to assist in implementing Committee recommendations. There will be five major areas of focus to begin with: wellness awareness, physical activity, nutrition, breastfeeding and smoking cessation.

The program is an expansion of a three-year effort to facilitate employee wellness based in the Department for Public Health. This former group developed a proposal that is serving as the basis for the expanded efforts of the Wellness Committee.

"Because we have had a program, we can make a concerted push forward now and be a model for the state. Our cabinet is filled with people who know the health care arena with expertise that will benefit our employees and all Kentuckians," said Secretary Holsinger.

The five areas of focus were chosen based on research by the initial former Public Health group on worksite wellness practices and a look at health issues in Kentucky. Kentucky currently has the fourth highest rate of obesity in the nation, and the state consistently ranks high on lack of physical activity. Earlier this year, the Department for Public Health partnered with the Get Healthy Kentucky! initiative begun by Governor Fletcher to hold a series of nine forums to discuss obesity around the state; more than 1200 people attended. The Wellness Committee is part of the administration's multi-faceted effort to improve the health of Kentuckians.
The 22 employees appointed to the Wellness Committee will gather ideas, suggestions and make plans for wellness activities in the cabinet as well as evaluating current practices and implementing new strategies. The membership reflects the diversity of the cabinet, with employees coming from throughout its programs.

State program staff have developed partnerships with local health departments, other state agencies, university staff and other public and private partners to become the main driving force in the identification of priorities in maternal and child health. These groups, with the addition of consumers of the services, comprise many advisory committees and ad-hoc committees. Our local health departments provide the "front-line" of defense against emerging health issues at the community level and are in constant communication with state staff. Additional information on health trends is obtained through resources nationally and from other states. Universities provide other resources including, but not limited to, analysis, research and training capabilities in various program areas.

Vital statistics data is used to support many of the maternal and child health performance measures. While Vital Statistics data has inherent flaws, it is considered to be our most accurate source of MCH data. BRFSS and YRBSS Survey data are available with sample sizes large enough to infer findings to the larger Kentucky population. Other data systems, such as PRAMS (Pregnancy Risk Assessment Monitoring Survey) do not currently exist in the state but Kentucky plans to apply for the PRAMS grant this fall. Additionally, the Youth Tobacco Survey administered to high school students added height and weight questions to estimate BMI among youth.

The Kentucky Birth Surveillance Registry (KBSR), primarily a passive surveillance system with targeted active surveillance contains highly accurate data. Now fully operational, the Kentucky Birth Surveillance Registry routinely monitors selected congenital anomalies and is also available for cluster investigations throughout the state.

Kentucky is included with states from the Great Lakes region in the Regional Genetics and Newborn Screening Grant for the purpose of enhancing the capacity of Kentucky to address prevention, screening, diagnosis and treatment of genetic conditions.

A neural tube surveillance system monitors the rate of NTDs in Kentucky, which has declined dramatically through the combined effort of the fortification of bread and Kentucky's local health department supplementation program to increase the number of women taking folic acid in their communities. This is a primary example of a success story that Kentucky hopes to emulate to other programs and health conditions.

Kentucky has obtained two federal grants, the State Systems Development Initiative grant and the Early Childhood Comprehensive Systems grant to study system infrastructures through data integration and linkages.

The Early Childhood Comprehensive Systems grant will examine current services and identify potential service gaps within five areas Early Childhood Development; Health Insurance/Medical Home; Mental Health/Social-Emotional Development; Early Care and Education Child Care and Parent Education and Family Support. Each subcommittee will meet to discuss issues and provide recommendations.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual					

Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	99.5	99.5	95	95	95.5
Annual Indicator	99.5	94.6	94.3	96.3	96.3
Numerator	51413	53233	52775	53381	53381
Denominator	51672	56266	55990	55413	55413
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	96	96.5	97	97	97

Notes - 2002

Data reporting for 2001 for this measure has been improved over past years. Prior years did not note births by occurance; rather reported was resident births.

The new total of 94.5 percent represents a far more accurate account of total births in Kentucky, total numbers of children screened. Data collection and the annual indicator for this measure will continue to improve in the future as additional resources are directed to Kentucky's Newborn Screening Program.

a. Last Year's Accomplishments

General Program Information : Newborn Screening in Kentucky

The 2005 Kentucky General Assembly passed Senate Bill 24 which expands Kentucky's Newborn Screening Program from the current four (4) disorders to the twenty eight (28) recommended by the American College of Medical Genetics. Kentucky will also continue to provide the Newborn Hearing Screening through the Commission for Children with Special Health Care Needs.

Newborn screening tests are performed by the Kentucky Department for Public Health, Division of Laboratory Services. Follow-up for positive screens is coordinated by the program administrator of the newborn screening program in the Division of Adult and Child Health Improvement. Additionally, contracts exist with both the University of Kentucky (UK) and the University of Louisville Medical Centers to provide medical consultation. Upon receiving a confirmatory diagnosis of the screening result, the university medical centers engage in patient/family education, medical management and training throughout the state. Formula and food products will also be provided for individuals with metabolic conditions including PKU when a third party payer source is unavailable.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. NBS Business Partner meeting to identify key issues.			X	X
2. NBS Advisory Committee development and regular meetings.			X	X
3. Consumer Involvement - Parent and Adult Consumers throughout all aspects of the NBS program.			X	X
4. New data system for NBS program within Department for Public Health.			X	X
5. The NBS will be expanded to a total of 29 disorders.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Current Activities:

With the passage of Senate Bill 24, the Department for Public Health, Adult and Child Health Improvement staff have been meeting and working with their partners, the Division of Laboratory Services, the Commission for Children with Special Health Care Needs, clinician specialists from the University of Kentucky and the University of Louisville and other interested parties to expand testing quickly but carefully. Workgroup members have been divided into subcommittees to look at Education, Laboratory/Screening, Short-Term Follow-up, Case Management, Diagnosis/Management, Evaluation and Newborn Screening Program/Administration. Staff have also been revising Kentucky Administrative Regulations to reflect the change in the statue.

The Tandem Mass Spectrometry equipment has been ordered for the lab and lab staff have attended training with Piero Rinaldo, MD, PhD with the Mayo Clinic College of Medicine.

A new data system for the Newborn Screening program is being developed within the Cabinet for Health and Family Services. The Laboratory Information Management System (LIMS) is an in-house data system that will assure accurate data collection and reporting for the program and allow communication between the state laboratory and the Newborn Screening follow-up staff that are located in the Division of Adult and Child Health Improvement. Specifications for this system are currently under development.

Kentucky currently participates in a HRSA Regional Genetic and Newborn Screening Collaborative Grant with the Great Lakes states. This grant assists to develop methodologies to assure availablity of appropriate genetic services.

c. Plan for the Coming Year

Plan for the Coming Year:

Expanding testing to include all 28 tests for inborn errors of metabolism and other inherited disorders will be the goal of 2006. Newborn Hearing Screening will continue to be done by the Commision for Children with Speical Health Care Needs and is regulated by seperate regulations. Disorders will be added to the current screening panel as laboratory equipment and validation of the testing is completed by the state lab. Contracts are in place with the University of Kentucky and the University of Louisville Metabolic, Pulmonary, Genetic and Hematology Clinics for appropriate treatment and management.

An educational brochure for parents on newborn screening has been developed and with the new legislation, hospitals are required to provide this information to parents.

New informational fact sheets and brochures are being developed with specific disease information and resourses. These brochures will be distributed statewide to hospitals, local health departments, Lamaze instructors, OBGYN's, pediatricians, and other health professionals and will be available on the Department for Public Health website.

Training curriculum are being developed by Adult and Child Health Improvement staff with sessions designed to train hospital staff, local health departments, Lamaze instructors, OBGYN's, pediatricians, family practice physicians, and other health professionals and will be available on the Department for Public Health website.

Information about the expanded newborn screening, updates on the expansion and information about the conditions included on the screening test will be available on the Newborn Screening Program website at
http://chfs.ky.gov/dph/ach/newbornscreening.htm during the six month roll out period.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				61	63
Annual Indicator			60.9	53.2	61.3
Numerator				4267	5651
Denominator				8025	9214
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	65	67	69	70	70

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

For the report due on July 15, 2004, the denominator reflects those children 0-21 enrolled in Kentucky’s CSHCN program receiving medical services; this program does not provide services to the larger number of children that could be identified in the state using MCHB’s broader definition of CSHCN. The numerator reflects those patients 0-21 receiving medical

services whose families have participated with their treatment team in identifying and resolving issues related to the patient's health and independence. This number is expected to increase as the requirement for staff to enter this information electronically was initiated during FY 2003.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

A survey of Commission families conducted by the interdisciplinary Human Development Institute, University of Kentucky, and PiINK (the state Family Voices affiliate) during the summer of 2003 reported that 98.4% of respondents receiving services from the Commission said they were satisfied with the services they were receiving.

-There are now two parents of cyshcn serving on the Board of Commissioners; efforts are underway to replace a youth who resigned due to illness.

- A developmental transition checklist was added to CUP (the Titile V web-based care coordination and information system) to serve as an assessment and counseling tool for families/youth. The checklist covers the knowledge, attitudes, and behaviors that lead to competency in directing personal and family healthcare and provides a means for measuring family and youth participation in the care they receive. Performance data for FY 03 are not complete as use was limited to pilot sites during most of the period.

- Budgetary constraints forced cancellation of contracts with two family advocacy organizations, KY-SPIN and PiNK. In anticipation of the funding cuts, CCSHCN initiated A PLANNING PROCESS (BLT -- building linkages for transition) with KYSPIN and other partners to explore funding opportunities. This became the basis for the STRONG Partnership (Strengthening Transition Resources & Opportunities in Neighborhoods grant) -- a Family support 360 Planning Grant from the Administration for Developmental Disabilities to develop a transition resource center in Louisville Metro's one-stop centers. The Commission is the grant's principal investigator. Two project coordinators were hired to implement the grant. One is a family advocate employed by KY-SPIN. The other is employed by the Community Mental Health/Mental Retardation Board.

- State general funds were awarded to each of the state's 15 District Early Intervention Councils (DEIC) to support parent participation and involvement at the regional and state levels in regards to early intervention services delivery. Since the Commission no longer administers the early intervention program financial support is now the responsibility of the Department of Public Health.

- Linda Miller was appointed in 2002 to coordinate family participation in policy and program development. She is continuing to develop the role, to identify and recruit family leaders, and to network and collaborate with other family advocates. She is active in UP in KY (United Partners in Kentucky), a functional non-compensated partnership to support family-agency collaboration and sharing of expertise and public advocacy for children and youth with special health care needs and taken a leadership role in developing the UP in KY web site that includes an extensive array of resources for families and information about public policy initiatives impacting cyshcn and their families.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. New data system for NBS program within Department for Public Health.				
2. Family members and Title V/CSHCN recipients serve on agency Board and various advisory committees.				
3. Parent-professional serves as family participation/liaison on staff of Title V/CSHCN agency.				
4. KY-SPIN family representatives are co-located in CCSHCN offices; identify issues & provide recommendations for improving service delivery				
5. Implement the requirement that all care coordination staff complete a care plan with the active participation of CYSHCN and their family.				
6. Implement a family satisfaction survey in conjuntion with the 5-yr MCH needs assessment				
7. All CCSHCN offices will assess the degree that they incorporate cultural & linguistic competence into their programs				
8.				
9.				
10.				

b. Current Activities

A staff member has been designated to support Title VI compliance. Significant progress has been made in having Commission forms and signs translated to Spanish.

- KY-SPIN family representatives are co-located in CCSHCN offices statewide on a regular basis. KY-SPIN reports include identification of issues and recommendations for improving service delivery.

- Regional nurse administrators are developing a care plan to be used by nursing and social work staff. The plan mandates participation of family and youth/child in the identification of person and family-centered priorities and outcomes. It expands agency capacity to monitor staff performance, document outcomes, etc. and reinforce families and youth as full partners in decision-making.

- Two parents of children with special needs have been hired as consultants by the Commission to work with KY-SPIN. They will provide consultative services to Commission youth and parents in neurology and orthopedic clinics in the Owensboro office.

The care plan is intended to address a concern documented by an external evaluator in the final report for our HRTW transition grant (1999-2003

c. Plan for the Coming Year

- Continue the above
- Implement an ongoing family satisfaction survey.

After reviewing available data from the National survey of Children with Special Health Care Needs, Kentucky census data, 2003 Kentucky Kids Count data, CDC data, State Demographic data, and the National Drug Endangered Child Council, it became clear that East Kentucky had some specific problems unique to that part of the state. One of the most surprising findings was the large percentage of grandparents raising their grandchildren. As a result the Regional Manager and staff plan to initiate and participate with community partners in projects to ensure that support systems are established so grandparents can easily access care.

- Continue collaborations with statewide parent organization to provide insight when developing

programs, expanding outreach efforts, and planning educational tools for the special needs population.

- Continue work to form a youth advisory council.

- Maintain parent professional staff position in Louisville.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				56	95
Annual Indicator			55.6	95.3	90.4
Numerator				7951	8327
Denominator				8344	9214
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	95	95	95	95	95

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

A data snapshot taken on 1/22/03 showed that 95.36% of Commission enrollees in the state were linked to a medical home as indicated by a Primary Care Physician listed in the individual medical record. This is considerably higher than the SLAITS survey information for KY showing 55.6% of cshcn reporting coordination of comprehensive care within a medical home and reflects the impact that the agency does have with its' targeted population of children with specific physical diagnoses.

Notes - 2003

For the report due on July 15, 2004, the denominator reflects those children 0-21 enrolled in Kentucky's CSHCN program receiving ongoing services; this program does not provide services to the larger number of children that could be identified in the state using MCHB's broader definition of CSHCN. The numerator reflects patients 0-21 receiving ongoing services who have identified a health care provider whom they see for their primary care.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

-- 95.2% of children & youth enrolled in the Title V medical program had a medical home.

- Entities that enter into a personal services contract with CCSHCN to provide medical services and/or care coordination to cyshcn are required to coordinate care with the medical home as a condition of their contract.

- CCSHCN entered into contract with the University of Kentucky Division of Pediatric Hematology/Oncology on behalf of the university's hemophilia treatment center (UKHTC) to provide outpatient pharmacy services for managing utilization and dispensing clothing factor under the Public Health Services discount pricing program to children and youth who are enrolled in the CCSHCN Hemophilia Program. The pharmacy management program is intended to optimize patient health, while minimizing the need for factor and managing its use. It will provide an avenue for educating patients and their primary care physicians, about the latest clinical practices and other important treatment issues. By introducing pharmacy management and supporting the UKHTC's participation in the 340B program, CCSHCN expects to realize better disease management and health outcomes as well as reduced program costs. The program will be evaluated with consideration given to expanding it to other areas of disease/pharmacy management for cyshcn as a potential quality and cost containment initiative.

- Staff made direct contact with the Area Health Education Centers serving their service areas. The AHEC's serve as a critical link to many primary care practitioners and to graduate medical education programs that secure placements for medical students, residents, and nursing and allied health students. In the future, this relationship may position us to expand our role in assuring access to systems of care, including the medical home, for all cyshcn and not just those served through the Title V specialty medical program. CCSHCN is approved by the Kentucky Board of Nursing to provide nursing continuing education units. We will explore the opportunity to partner with the AHEC's to provide community-based education and training for health practitioners, with a focus on the medical home; comprehensive, coordinated systems of care for cyshcn; and youth transition.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Data system tracks % of CSCHN enrollees with active PCP(95.36% in FY02)				
2. Clinic notes sent to physician of record within 5 days of enrollees visit to Title V/CSHCN clinic				
3. Outreach targeted to physicians identified as not referring to Title V/CSHCN				
4. Prepare journal articles and turnkey presentation to disseminate SLAITS data targeted physicians and other health, education, and human services providers as well as families and the community at-large.				
5. Conduct a provider survey as a component of the MCH 5-yr needs assessment; analyze availability & accessibility to primary care and specialty care and attitudes about family-centered care				
6. Conduct a family survey targeting families of CYSHCN who do not access Title V services to assess their access to a medical home and their satisfaction with care received				

7. Structure oppportunities for dialogue between families and health practitioners to discuss what constitutes family-centered care and how it can be incorporated into a variety of practice settings				
8. Provide medical specialty care in collaboration with the child's medical home				
9.				
10.				

b. Current Activities

- CCSHCN title V care coordinators record each enrollees medical home in our web-based case management and reporting system If no medical home is identified, the care coordinator works with the family and youth to identify a medical home and to establish a link with the medical home.

- Care coordinators are required, and performance is monitored through annual chart audits, to assure that the medical home receives clinic notes within 5 days a child or youth being seen in a CCSHCN clinic.

- Staff maintains direct contact with federally qualified health centers and school nurses who serve cyshcn within their service areas to support coordinated, comprehensive care.

- Referrals are monitored through reports produced by case management and reporting system. District staff contacts primary care physicians who are not referring cyshcn to the Title V program and those new to the area.

- Kentucky Patient Access and Care (KenPac) nurse case managers are co-located in several CCSHCN district offices. Ken Pac is a primary care case management program providing a "medical home" and a "primary care provider" to all KenPac enrollees who are Medicaid-eligible based on Transitional Assistance for Needy Families and adult Supplemental Security Income (SSI). The main goals of the programs are to increase primary and preventive services, coordinate use of other health care services including inpatient hospital and outpatient care, thereby improving quality and health outcomes, and controlling overall costs to the Medicaid program.

- CCSHCN Medical Director, who also sees cyshcn enrolled in our Title V medical program, and the nurse coordinator for our Elizabethtown office are on the board of Passport Health Plan, the state's single Medicaid Managed Care entity.

- CCSHCN Medical Advisory Group, which includes a pediatrician who is a recent past president of Kentucky Medical Association, meet quarterly.

- Several Commission offices are located in close proximity to local health departments and/or primary care centers. Several provide clinic space for specialty care such as early intervention intensive evaluations, neonatal follow-up and outreach by the university medical centers, etc.

c. Plan for the Coming Year

-95.2% of children and youth enrolled in the Title V medical program had a medical home, conversely the percentage of cyshcn that report having a personal doctor or nurse in the National survey was much lower (12.6% KY/ 11.0% US) To increase awareness, CCSHCN staff, with the assistance of KY-SPIN, will develop an article presenting National survey data and the 6 MCHB performance measures for publication in state family practice and pediatric journal.

- Staff will prepare a turnkey presentation for use by state and regional staff and board members on National Survey and the 6 MCHB performance measures for local presentation to medical professional, public policy makers, families, and other constituents.

District office staff at all levels and to the extent possible, their medical partner, will discuss with families of cyschn the attributes of family-centered care and how it can be incorporated into a variety of practice settings.

- As the Commission expands services to those not enrolled in our Title V medical program staff will encourage families to establish a medical home and assist families with identifying skilled potential PCP providers.

- Though the Title VI coordinator has been diligent in submitting Commission forms to the Cabinet's Spanish language interpretation division not all forms have been translated. She will continue to submit remaining brochures, forms and other resource material into Spanish to ensure the growing Spanish speaking population can readily access Commission services.

- Contact and collaborate with Hispanic Ministries and other Hispanic community resources to ensure that families are aware of the services provided by the Commission.

- Continue development of systems capacity to link the Title V information system (including the Universal Newborn Hearing Screening records) with birth records, the birth surveillance registry, early intervention, etc. to evaluate access to care, utilization of services, and health care outcomes.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				57	64.9
Annual Indicator			56.6	64.8	63.0
Numerator				6427	6247
Denominator				9913	9913
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	65	65	65	65	65

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

As with the performance measure related to cshcn linkage to a medical home, the % of Title V/CSCHN enrollees with insurance coverage is significantly higher (91.18% in FY02) than the % reported for the general population of KY cshcn in the SLAITS survey (56.6.%)

Notes - 2003

For the report due on July 15, 2004, the denominator reflects those children 0-21 who accessed services through Kentucky's CSHCN program; this program does not provide services to the larger number of children that could be identified in the state using MCHB's broader definition of CSHCN. The numerator reflects those children 0-21 accessing services who have Medicaid insurance, with and without private insurance, since they could access their required care without being enrolled in the CSHCN program.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Per 2001 National Survey of Children with Special Health Care Needs:
- 6.4% of cyshcn in Kentucky (52% US) are uninsured
11.5 % of cyshcn in Kentucky (11.6% US) were without insurance at some point during the past year
-38.1% of cyshcn in Kentucky (33.8% US) between the ages 0-17 are insured with coverage that is not adequate

- Among cyshcn enrolled in the Title V medical program, 66.3% (0-18) and 64.3% (0-21) have adequate insurance if one considers that children and youth with Mediccaid as a payor source have adequate insurance to pay for the services they need.
-Conversely, one in three cyshcn served by the Title V medical program do not have adequate private and/or public insurance to pay for the services they need.

The number of cyshcn without adequate private and /or public insurance to pay for the services they need is expected to increase. Evidence also suggests that many "families are having difficulty in meeting out-of-pocket expenses. The Kentucky Long Term Policy Research Center reports that "families are scrambling to reconstruct budgets that will enable them to meet the cost of health insurance, which, if available, now rivals that of housing for some (2003)." The Center reports in its 20004 report on health care in Kentucky that "Cost, access, and the quality of health care, which relates to both cost and access, have proven to be the perennial public policy concerns…Continued slow job growth has worsened the situation, curtailing revenues that might finance remedies at the state and federal level and increasing the number of citizens of all ages who need help with meeting the cost of health care."

Surveys of graduates exiting the Commission program between the ages of 18-21 indicate that 35% have no health insurance compared with 27% of youth age 18-24 in Kentucky. Similarly, a number of parents with no insurance or inadequate insurance are unemployed or under-employed.

As employment and earnings have been demonstrated to be a strong predictor of health insurance coverage, CCSHCN staff was the lead writer in a grant for funds from the US Department of Labor to improve access to youth with special health care needs and families of cyshcn to services offered by one-stop employment and training centers in the Louisville Metro. The proposed scope of work was developed collaboratively with the local Workforce Investment Board, Department for Vocational Rehabilitation, and Center for Accessible Living (which has a federal grant to provide benefits counseling services for SSI/SSDI recipients.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Title V/CSHCN financial eligibility considers existence of 3rd party resources and covered benefits.				
2. Data system tracks % of enrollees with source of payment.				
3. Care Coordinators trouble shoot coverage issues with 3rd party payors				
4. Workshops train families to work with 3rd party payors to coordinate benefits/advocate for coverage.				
5. Re-enforce personal responsiblity and self-care and appropriate useof health care resources, including use of preventive care through care coordination & family education				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The current process for determining eligibility for Title V medical services includes documentation of insurance/Medicaid status and an annual financial update. In addition to reviewing third party resource, covered benefits in existing policies are reviewed. Families and youth living independently receive assistance in applying for Medicaid, KCHIP (SHIP), and SSI.

- The intake branch manager and several members of her staff have extensive expertise in health insurance matters as former managers and/or employees of major insurance providers. They are available to assist families and care coordinators in dealing with insurance issues.
- Family education includes access financial resources and working with 3rd party payors to coordinate benefits and advocate for coverage.

c. Plan for the Coming Year

- Governor Fletcher, a physician and former member of US Congress, is committed to improving the health of Kentuckians, however, he notes:
"We are sorely lacking in public education on health habits of living. We need to promote preventive medicine. These issues are especially important to me- which is why we will modernize Medicaid to make it easier to access, and to empower people to take control of their own healthcare."

To this end, the CCSHCN will continue to take an active role through care coordination and family/patient education to reinforce personal responsibility and self-care and appropriate use of health care resources, including the use of preventive care.

Through funds allocated to CCSHCN from the MCHB grant for State Systems Development Initiative (SSDI), we are working to develop an interface with Medicaid files, which will allow us to evaluate utilization and highlight areas in which we can be more proactive in working with families to ensure utilization of preventive services (such as EPSDT), better management of chronic conditions and prevention of secondary conditions, and support appropriate us of

medical transportation, emergency room services, and in-patient hospitalization.

Though preliminary results of the needs assessment are consistent with the 2001 National Survey of Children with Special Health Care Needs we will closely monitor the effects of stricter documentation requirements for KCHIP application process.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective					77
Annual Indicator			74.9	76.9	81.2
Numerator				6170	7484
Denominator				8025	9214
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	78	79	80	81	81

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

For the report due on July 15, 2004, the denominator reflects those children 0-21 enrolled in Kentucky's CSHCN program receiving medical services; this program does not provide services to the larger number of children that could be identified in the state using MCHB's broader definition of CSHCN. The numerator reflects those patients 0-21 receiving medical services whose families receive ongoing care coordination assistance with accessing community resources and additional specialty health care. This number is expected to increase as the requirement for staff to enter this information electronically was initiated during FY 2003.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Western KY Program Coordinators developed the Care Coordinator Guide to the Transition Checklist, which incorporate Bright Futures and other developmental assets. The three volumes, which supplement the transition checklists, offer guidance and information for health

professionals, families and youth on comprehensive array of resources supporting social and physical health and development. It is expected to be a great resource for use in building local systems of care as it identifies the comprehensive array of services and supports that should be available and accessible to families. There has been great local interest among our partner agencies in obtaining copies of these guides.

The Commission is the principle investigator in partnership with KY-SPIN and the regional mental health agency, Seven Counties Services, in a planning grant for the development of a disability resource center in Louisville Metro's Neighborhood Place one-stop centers. Supported by a Family 360 Grant from the Administration for Developmental Disabilities, the centers house staff from the Jefferson County Public Schools, Louisville Metro health Department, Louisville Metro Human Services Department, and the State Department for Community Based Services (TANF, food stamps, Medicaid eligibility, etc.) Three of the eight Neighborhood Place centers are participating in the pilot because they serve communities with a higher number of racial/ethnic/cultural minorities. Through the community planning process, we are developing a framework for expanding the one-stop development process to other areas of the state.

CCSHCN, PiNK (KY Family Voices affiliate), the Owensboro Down Syndrome Association and KY-SPIN collaborated with the UK Interdisciplinary Human Development Institute to disseminate the Consumer and Family Satisfaction Survey through July 31, 2003 (of which IHDI is the author). Over 1400 survey questionnaires were distributed to CCSHCN offices with 36.4% (n=510) returned. The survey instrument was also widely publicized through electronic list serves targeting families of cyshcn with 136 electronic surveys completed.

Findings from among all respondents (not just families served by the Commission):
61% of respondents reported that a family member had a physical disability
7% reported that their family member had a mental disability
24% reported both a physical and mental disability

Concerning unmet needs, families responded:
Urban/Rural
Health care 15.1%/ 22.4%
Education 12.3% /21.0%
Recreation 20.5% / 13.6%
Transportation 13.7%/ 10.3%
Employment 15.1% / 6.3%
Housing 8.2% / 5.3%
Respite 2.7% / 2.9%
Other 5.5% / 7.2%
No current unmet needs 6.8% / 12.5%
Commission results regarding unmet needs aligned closely with the total responses (21.3% reported health care needs; 18.4% reported education needs; 13% reported no current needs). In comparison, National survey data indicate that 14.8% of KY cyshcn (17.7% US) had 1 or more unmet needs for specific health care services.

Respondents reporting

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				

2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

- Community outreach is incorporated into position descriptions and performance evaluations. Comments from the staff survey indicate attitudes are changing about the role of the Title V cyshcn agency from a clinic to care coordination/systems of care model.
The executive director was appointed to the State Department of Education's Special Education Advisory Committee; the Commission is also represented on the State Interagency Coordinating Council; KIDS Now Partnership for early childhood; the State Co-Occurring Disorders systems development workgroup, state Interagency Transition Workgroup, etc. and a number of other state and local taskforces and committees. Active participation is occurring at the district level including District Early Intervention Councils.

c. Plan for the Coming Year

See above
- Implementation of a care plan is expected to further enhance our performance in this area
- We plan to expand the one-stop planning model to other areas of the state.
-
- Pursue Memoranda of Understanding with partner agencies/organizations, regardless of whether money is exchanged, to include specific actions that each party will take to assure that systems of care are organized so that families can use them easily and the identification of quantitative and qualitative indicators for monitoring and reporting performance.
- Continue to foster attitudes among staff that lead them to see how they, as public health professionals, can contribute to ensuring that systems of care for cyshcn and their families are organized so that families can use them easily.
-According to Kentucky's 2003 foster care census 61% of the 6,500 children in foster care at the time had at least one disability. Approximately 150 foster children in Kentucky were classified as medically fragile. The Commission recognized this as an opportunity to serve children who were not within the scope of the Commission's traditional population. In collaboration with DCBS, the Commission implemented a medically fragile foster care pilot project. The objectives are to provide nursing consultation for children in foster care and to provide education and ongoing training for foster parents. [Services provided thus far include fluoride varnish, medication, nutrition care coordination, home visits. Two children were enrolled in the Commission's Cardiology and UNHS programs for additional services.] Given the success of the pilot, the Commission and DCBS have agreed that this project will gradually be expanded to 2 or 3 regions in western Kentucky over the next 6 months. Our long term goal is to include all 14 regions across the state. The current memorandum of understanding (MOU) has been extended through June 30, 2006.

The Kentucky Obesity Epidemic 2004 report generated a tremendous amount of concern about all of Kentucky's citizens but in order to have the greatest impact on improving the future health of our citizens we must begin with our youth. This report determined that 15% of Kentucky's

youth are at risk for being overweight or obese as adults if something does not change. [Among high school students in Kentucky, 14.6% (10.5% US) are overweight and 15.3% (13.6% US) are at risk. The percentage of high school students in Kentucky who are physically inactive (10.5%) was comparable to that found in the nation (9.5%).]

Commission staff expressed concern that this "epidemic" is even more pronounced among the special needs population that we serve since many health conditions impair or restrict physical activity. To address this problem each region plans to implement activities, some in collaboration with community partners, e.g. Parks Depts. Health Education Ctrs., Headstart groups, to promote fitness and nutritional programs for the special needs population.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				10	50
Annual Indicator			5.8	28.3	72.0
Numerator				503	1250
Denominator				1779	1737
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	51	52	53	54	54

Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

· Since 1999, the Commission’s Health and Ready to Work Grant, the Kentucky Youth Transitioning to Employment and Comprehensive Healthcare Project (KY TEACH) has provided support for collaboration with a variety of organizations to increase community awareness of the significance of a medical home for individuals with special needs, to encourage yshcn to complete their high school education and seek further education or vocational training and to prepare youth to enter adulthood as individuals “healthy and ready to work “.
KY TEACH entered the 3rd of its 4-year award period during FY 2001. The grant has allowed the Commission to become a national leader in transition services. Highlights and successes of the grant include: 1) institutionalization of transitions into agency organization and function through administrative reorganization and appointment of transition liaisons in each of the

regional offices; 2) developing electronic capacity to track data on enrollees linkage to their medical homes; 3) collaborating with family and independent living organizations to increase the probability that families and youth with special health care needs (yshcn) can manage successful transition of yshcn to adult health care, work, and participation in the community; and 4) developing relationships with a variety of organizations to improve workforce participation by yshcn, offering individual coaching and group training to teens and supporting youth in paid work experiences.

Notes - 2003

For the report due on July 15, 2004, the denominator reflects those youth 15-21 enrolled in Kentucky's CSHCN program receiving medical services; this program does not provide services to the larger number of youth that could be identified in the state using MCHB's broader definition of CSHCN. The numerator reflects those patients 15-21 receiving medical services who have discussed plans for accessing adult health care providers (primary, specialty, dental, DME, pharmacy, therapy, and mental health). This number is expected to increase as the requirement for staff to enter this information electronically was initiated during FY 2003.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Over the past decade, Commission staff has worked tirelessly to develop an infrastructure that supports successful transition from the time children and families make contact with the Commission until they are discharged for reach their 21st birthdays, This effort has been generously supported by MCHB, most recently through a Health & Ready to Work grant which expired September 30,2003. Transition activities have been incorporated into the overall title V specialty medical and care coordination program.

Both Kentucky and the Commission are firmly committed to establishing systems of care that assist youth with disabilities to successfully transition from school to the community. In order to facilitate the collaborative process eleven Regional Interagency Transition Teams have been established. RITT team members were invited to participate in 2 separate one-day orientation conferences to begin exploring ways in which they could effectively work together. These teams will meet quarterly to continue the interagency collaboration process for the benefit of Kentucky youth with disabilities as they transition from school to community. Lee Gordon and Pat McKown represent the Commission on the State Transition Core Team and serve on the RITT in their respective regions.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities

- The developmental transition checklist is used by all care coordination staff to identify and assist cyshcn and their families in developing the personal and family competencies (attitudes, skills, and behaviors) which will support self-determination and lead to successful transition.

- Central office has senior level staff assigned to coordinate transition-related programming and services and to serve as a resource to staff and other state and local partners

- CCSHCN is the State Title V partner in the MCHB funded National Healthy & Ready to Work Center

- Each CCSHCN office has a designated transition coordinator, referred to as the "TEACH liaison"

- Requests for proposals and personal services contracts now require each contracting entity to describe how they will address youth transition and the other 5 MCHB performance measures as a condition of their contract

- CCSHCN continues to partner with transition liaisons from the state's special education cooperatives to identify collaborative strategies for strengthening transition, including Disability Mentoring Day, which has been a huge success in most regions of the state:

National Disability Mentoring Day is a big event in Hazard. CCSHCN staff have secured the participation of a very diverse and locally powerful planning group, including local elected officers, school administrators, small and large employers and other community partners. The members of the partnership, which have seen first hand the potential that youth with special health care needs represent to the area's labor force, return year after year to volunteer as mentors. Through word of mouth, the number of employers signing up to be mentors increases year after year. Last year, there were more employers signed up to be mentors than there were youth. The mayor proclaims the day as Hazard's Disability Mentoring Day, the school system provides transportation, and the rest of the community kicks in to make it happen. Other counties in the region are now participating and cyshcn in the region have a vast network of very powerful and influential supporters championing their success.

- CCSHCN continues to build upon the success of the Paducah office in providing a forum for teens with disabilities to serve the community, experience new opportunities, and above all to have fun. In most regions of the state, CCSHCN is actively supporting youth participation in local boys and girls organization, including Girl Scouts, community-based adaptive recreation programs, camps, etc.; and assisting other organizations to expand their services or create new opportunities for youth to volunteer, learn, and have fun (such as the Louisville Youth Group which is a collaborative venture between CCSHCN, the Center for Accessible Living, and Metro Parks Department).

c. Plan for the Coming Year

- Develop a Memorandum of Understanding with the State Department of Education which identifies specific actions that each will take to promote transition of children and youth with special health care needs, assist local education agencies in bridging the achievement gap, and support the identification and inclusion of health-related issues in the student's IEP and individualized Graduation Plan.
- Support Governor Fletcher's JOBS for Kentucky initiative by working with vocational rehabilitation, accessible living centers, Workforce Investment boards, and business initiatives

to link youth with special health care needs and their families to local employment and training resource, literacy and GED programs, and other local services and supports such as the state's child care resource and referrals centers.
- Intensify efforts to recruit children and youth with special healthcare needs to participate in a Youth Advisory Council in their district.

Participate with local RITTs to enhance alignment with schools and other agencies to attain improved outcomes for youth as they transition from school to the community.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	83	80	76	77	77
Annual Indicator	81.8	75.9	72.3	81	81
Numerator	43495	40358	35842		
Denominator	53173	53173	49575		
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	82	82	84	84	84

Notes - 2002

Data for immunization is not available through the CDC NIP Survey.

Notes - 2003

Data from CDC NIP Survey
Calendar Year 2002 72.3% +/- 6.4% CI
Data for immunization is not available through the CDC NIP Survey.

Victor Negron, Contact
Kentucky Immunizations Program

Notes - 2004

Data for immunization is not available through the CDC NIP Survey for 2004. Data provided for 2004 is from 2003

a. Last Year's Accomplishments

General Program Information - Immunizations in Kentucky

Within the Department for Public Health, the Division of Epidemiology is the lead division for the immunization program. Programs operated by the Title V agency and local health departments routinely assess immunization status. Immunizations are provided through the local health departments and supplied through the Department for Public Health. Recent legislation funded the cost of vaccines for underinsured children. This program expansion is one of the items within the early childhood development program.

Data for this measure is provided by the CDC's National Immunization Survey (NIS). The NIS has been conducted annually since 1994 by the National Immunization Program and is used to obtain national, state, and selected urban area estimates of vaccination coverage rates for US children between the ages of 19 and 35 months. The NIS is a random digit dialing telephone survey of households with age-eligible children followed by a mail survey of the children's vaccination providers to validate immunization information. National vaccination rates are based on the entire survey sample of more than 30,000 completed interviews. The sample size for each state is considerably smaller and for this reason has a much larger confidence interval.

A child's immunization status is assessed and referrals are made at many points within the health, education and social service delivery system. Specific programs within the Division of Adult and Child Health Improvement that effect this measure within preventive and primary services for children include the following: Regional Pediatrics Program; Child and Youth Project; Well Child Program; Health Access, Nurturing Development Services (HANDS); WIC; and Healthy Lifestyle Education.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Purchase of vaccines to cover the underinsured, non-Medicaid and non-KCHIP	X		X	
2. Continued financial support for immunizations from KIDS NOW! ($2 million)			X	X
3. Continued program activity by the Division of Epidemiology Immunization Program			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The purchase of vaccines to cover the underinsured population of children, who are non-Medicaid and non-KCHIP eligible, will increase access to immunizations. This program was fully implemented in August of 2000. Two million dollars has been added to the FY 05-06 biennial budget. Approximately 6,500 underinsured children have been immunized during FY 04-05. That is approximately a 15% decrease in number of children served from the previous

year. However, the cost of vaccines rose approximately 10% from 2004 to 2005, influenza vaccine was added to the recommended schedule in 2004 and the combination vaccine, Pediarix, was added to the CDC contract. These variables reiterate the fact that while the funding does not increase from its initial amount of two million dollars, the cost to vaccinate a child increases each year. Therefore, the number of underinsured children serviced under the KIDS NOW initiative should decrease annually.

Regardless, in 2003, the immunization rate for this measure in Kentucky was 81.0 percent, an 8.7 percent increase over the 2002 rate of 72.3 percent.

The Kentucky Immunization Program distributed a significant amount of vaccine for administration to children from birth through 18 years of age. Transaction data for 2003 shows that 615,518 vaccine doses were distributed to public providers and 304,112 vaccine doses were distributed to private providers, for administration to Kentucky children.

c. Plan for the Coming Year

Once again, $ 2 million has been allocated by the KIDS NOW Early Childhood Initiative to support Kentucky's immunization program. Activities for FY 05-06 will be similar to those listed in the previous sections.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	34	29	28.9	29	29
Annual Indicator	29.1	25.2	24.9	24.8	23.0
Numerator	2401	2211	2054	2012	1866
Denominator	82452	87743	82452	81198	81084
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	21	21	20	20	20

Notes - 2002

Vitals Data for 2002 is not yet available. It will not be available until spring/summer of 2004. Data from 2001 is still provisional.

a. Last Year's Accomplishments

Preliminary Rate 2004 is 23.0/1000 for teens (15 -- 17 years old)
Preliminary data for 2004 indicates a rate of births for teens (10 -- 19 years old) at 23.7/100, which is a continuation of the downward trend from 2003 rate of births for teens at 24.9/1000.

The rate for 18 -- 19 year olds fluctuates annually.

Preliminary data for 2004 indicates a rate of births for teens (10-19 years old) at 23.7/1,000, which is a continuation of the downward trend from the 2003 rate of births for teens at 24.9/1,000. The rate of births to teens 15-17 years old decreased from 30.2 in 1999 to 23.0 in 2004. Births to younger adolescents (<15 year olds) remained steady at 0.8 per 1,000, while the rate of births to 18-19 year olds declined, down from 93.0 in 1999 to 82.8 per 1,000 in 2004 (Kentucky Vital Statistics 2004).

Two major focuses of Kentucky's Abstinence Education grant are positive youth development, through teaching values and practical skills to abstain from sexual activities, and the development of strong partnerships among non-profit public and private community agencies, faith-based organizations, parents, and schools. The Department of Public Health will issue two Request for Proposals; one which solicits contractors from local health departments, and the second which solicits contractors from non-profit, non-governmental agencies to submit project proposals designed to lower teen pregnancy rates in Kentucky.

A full array of reproductive healthcare services for individuals of all ages is available through federal Title X funds allocated to local health departments. Services include client education, counseling, history, physical assessment and laboratory testing, fertility regulation, infertility services, pregnancy diagnosis and counseling, adolescent services, gynecologist services and sexually transmitted disease testing and treatment. 114,850 women, men, and adolescents were served through the Title X program in calendar year 2004. Of those served, 34,885 were between the ages 15-19. These services provide primary and preventive health intervention services for adolescents. The services for adolescents that effect this measure include: the School Health and Adolescent Preventive Health Services, Family Planning for Teens, Teen Pregnancy Prevention, Abstinence and Healthy Lifestyle Education.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contiuation of Postponing Sexual Involvement and Reducing the Risk programs			X	
2. Continued training opportunities through Title X Family Planning funding support.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

School and community-based abstinence education curriculum are specifically designed for adolescents between the ages of 10 -- 19 years old. Some programs are taught by peer educators who reinforce the message through positive peer pressure. There is a wide range of topics in the curriculum which are essential in healthy maturation, including refusal skills,

awareness of media messages, and peer pressure. There are several abstinence-only projects that fall under this category: Postponing Sexual Involvement (PSI), Choosing the Best, and Teen and Youth Program (TYPE).

Reducing the Risk (RTR) is taught to approximately 30% of Kentucky's ninth grade students, but is not funded with federal abstinence grant dollars because contraceptive education is included as part of the curriculum. It focuses on avoiding unprotected intercourse through abstinence as the only 100% safe method but also includes several sessions on contraceptives and their proper use. Currently (2004-05 school year), approximately 21,000 students at the 9th grade level received RTR in 115 schools. The Kentucky Department of Education's core curriculum states that ninth graders are required to have 1/2 credit of health education. Many schools choose abstinence education to meet this requirement.

Family Planning initiatives for FY 05 include two Hispanic clinics targeting low income under insured Hispanic clients; Teen Pregnancy Prevention Intervention Program servicing a teen reproductive health clinic; Young Parents Program provides intensive counseling to teens to prevent teen pregnancies and repeat teen births; Brighton Center Youth Development Program teaches youth positive youth development skills and refusal skills towards risk taking behaviors; Family Participation Workshops encourage family participation in the decision of minors seeking family planning services; and finally, the Pike County Male Special Initiative Project services a local health department clinic, a college based clinic, and an in-school program for middle school males who are taught goal setting and self-esteem skills.

Kentucky is expected to receive $ 5,674,656 in federal Title X funding for FY06. Kentucky funds 160 Title X clinics, with the majority of this funding is allocated to local health departments to assure access to family planning services throughout Kentucky's 120 counties. Additionally, local health departments may opt to use a portion of their federal Title V Block Grant allocation to support family planning program efforts in their community. All Title X delegate agencies must have a sliding fee scale based upon federal poverty guidelines and must offer all methods of FDA approved contraceptives, including emergency contraceptive pills. Title X funding does not fund abortions.

c. Plan for the Coming Year

Several of Kentucky's 2006 Abstinence Education Program's goals include:

To decrease the rate of pregnancies among 15-19 year old females from 63/1000 in 2002 to 49/1000 by 2007.

To maintain or increase the number of 6th grade students participating in (pre-teen) abstinence-only based programs at 15,000 (FY05 number served).

To increase the number of Kentucky 7th and 8th grade students who are receiving abstinence-only curriculum from 35,000 7th graders in 1997, expanding to 62,000 7th & 8th graders by the year 2006.

To reduce the proportion of adolescents (ages 14-17) who have engaged in sexual intercourse from 50% in 2002 to 44% in 2007 (KY YRBS 2001).

To meet these goals and the needs of communities, local health departments decided to diversify abstinence-only curriculums from predominantly Postponing Sexual Involvement curricula to additional evidence based abstinence-only curriculums. Counties' autonomy to choose programs has created a sense of ownership and community interest furthering the diffusion of the abstinence-only message.

Kentucky's 2006 Family Planning Program's goals are:

100% of the estimated 241,290 women and teens in Kentucky, in need of publicly supported family planning services, to have them available.

Teens will delay sexual involvement and the pregnancy rate for teens 15 --17 years old will be reduced and teens will report less risk taking behaviors as reported in the Youth Risk Behavior Survey.

Unintended and/or mistimed pregnancies will be reduced to no more than 30%.

Women of childbearing age and men will have the information and means to protect themselves from sexually transmitted diseases and STDs will be reduced in this population.

To help meet these goals, Title X the program must continue to market services through community participation committees and community plans; prepare or recruit additional providers; continue outreach to hard-to-reach and vulnerable populations in non-traditional service sites already established; and expand non-traditional sites to new areas. Collaborations with community/school/health department teen pregnancy prevention initiatives in all 120 counties, while also promoting and conducting Parent Workshops through local health clinic's programs, will assist in promoting teens delaying sexual involvement and ultimately decrease the teen pregnancy rate.

Decreasing unintended and/or mistimed pregnancies can be achieved by monitoring the pregnancy rate for teens 15-17 years old and providing support and services to encourage sexually active teens to access appropriate services. Family Planning clinics will continue to provide medical counseling and all contraceptive choices, Pap tests, and STD testing including HIV.

During FY 2006, the Emory Regional Training Center for Family Planning will provide at least 14 reproductive health and related courses for family planning staff.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	25	30	30	32	35
Annual Indicator	21.7	29.0	29.0	29.0	29.0
Numerator	13000	16201	15855	15478	15222
Denominator	60000	55868	54675	53375	52489
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective	33	33	35	37	37

Notes - 2002

Population data for 2002 is not available.

Notes - 2003

Oral Health Staff expect this performance measure to be accurately measured in future years with the development of the Children's Oral Health Surveillance System which will provide ongoing data to track the status of children's oral health within Kentucky.

a. Last Year's Accomplishments

The 2003-2004 fiscal year was an exciting one for Kentucky's Oral Health Program. First, Kentucky was awarded an Oral Health Collaboration Systems Grant (MCHB/HRSA) which enabled the beginning of a Strategic Planning Process and an on-going Children's Oral Health Surveillance System for the state.

Kids Smiles Fluoride Varnish Program started in July 2003 as a part of the KIDS NOW Early Childhood Initiative. The purpose of Kids Smiles is: To prevent early childhood caries (ECC) through: (1) targeted early screening, (2) oral health education of caregivers, (3) application of a fluoride varnish to primary teeth (baby) if necessary, and (4) proper referral to a dentist if appropriate for care. Funding for KIDS SMILES in Kentucky's biennium budget $ 250,000 each year for two years.

A total of 13,091 services, which included oral health screenings and fluoride varnish applications, were provided to children by local health department nurses during FY 04.

Trainings were provided at twenty-three regional training sites to approximately 1100 health department nurses and other providers. Oral Health Staff provided over 15,000 pre-packed fluoride varnish kits to participating local health departments. A database for monthly tracking and reporting of local health department applications of fluoride varnish has been developed and a contract has been established with the Commission for Children with Special Health Care Needs to apply fluoride varnish to children (birth through five) under their care beginning Spring 2004.

With State General Fund dollars, Kentucky's sealant programs began in eighteen local health departments. In collaboration with local dental hygienists and dentists as well as community schools, local health departments were provided with funding to purchase portable dental exam equipment. These partners worked together to provide screenings and sealants on Kentucky 2nd, 3rd and 6th graders throughout the Commonwealth. Parents were informed on the program through informed consent signature forms.

In Kentucky, dentists must first screen the child and record which teeth are in need of sealants (Kentucky dental hygienists are under indirect supervision). In some cases, sealants are immediately provided by dentists or hygienists and in other communities, dental hygienists return to the school at another time to provide the sealants.

Finally, the University of Kentucky, College of Dentistry participates annually, in cooperation with the Department for Public Health Oral Health Program, in "Seal Kentucky" activities, including traveling with first-year student dentists and faculty to selected rural counties for the application of sealants for children who might not otherwise see a dentist. Traditionally scheduled in October, this activity is mutually beneficial for children and residents alike, with many residents noting that this opportunity was one of the highlights of their graduate experience.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide grants to selected local health departments to for the purpose of dental equipment purchase and dental provider partnerships for sealents.	X			
2. On-going support of the Kentucky Children's Oral Health Surveillance System, tracking oral disease and sealant use throughout the state.			X	X
3. Continued oral health education at the local level; to families, health providers (including nurses and physicians) and the community.			X	
4. KIDS SMILE fluoride varnish program, which includes not only the application of FV but also an education component for parents/families. Through the local health departments.	X		X	
5. Continued partnership with the University of Kentucky College of Dentistry and their SEALKENTUCKY program, reaching to children throughout the state and particularly in rural areas.	X	X		
6. Contined support of regional system for dental care, through cooperative efforts by the Director of Oral Health, DPH and partners throughout the state, increasing access in areas of provider shortages.				X
7. Ongoing strategic planning for children's oral health in Kentucky. Completed report by Fall 2005.				X
8.				
9.				
10.				

b. Current Activities

Kentucky's Sealant Program continues with twenty-three local health departments participating in FY05. Funding for on-going support for the Sealant Program continues to be provided by State General Fund dollars, with a total budget of $ 184,000 ($ 8,000 per site) in FY05.

Kentucky's Fluoride Varnish program is also on-going, with allocations of $ 128,000 and providing nearly 22,000 services to date for Kentucky children through local health departments.

The Kentucky Children's Oral Health Surveillance System will continued with pilot screenings beginning at Kentucky schools in Spring 2005 and will be on-going on an annual basis; rotating approximately one third of the random sample of schools off each year and replacing these with new schools.

The project includes surveillance of 3rd and 9th grade Kentucky public education students. The sampling is designed as a cumulative replicate sampling over three years. Each sample in each year will be a representative sample of the state's 3rd and 9th grade students, and will also allow for merging as a cumulative sample over the three year period, allowing for more precise estimation overall, and for subpopulations. Implicit stratification will be employed by sorting lists of schools containing 3rd and 9th grade students.

Lists are sorted first by Area Development Districts (ADD). ADD geographical areas are believed to provide relevant division of the state by geographic, social, and economic factors, and are therefore useful for gaining subpopulation estimates by ADD, for describing the state of

oral health in the school age population, and for program planning and implementation. The list is further sorted within ADD to ensure representation by distributing sample selections across other important factors believed to be related to oral health. Depending on the ADD, schools are sorted by urban/rural status, county, and percentage of enrolled students eligible for the free/reduced lunch program. A slightly higher rate of sampling proportional to population size was employed in the smallest ADDs to ensure that one school is selected in each of the 15 ADDs in each year of the three year period.

Because the sample is of sufficient size to be weighted to five Kentucky regions (North, West, Central, East and Jefferson area) annually and to the fifteen ADDS in every third year, the resulting information should recognize subpopulations of the state not previously examined.

Additionally, the collection of Body Mass Index (BMI) information will provide agency health professionals with a statistically accurate sample of under/overweight for Kentucky 3rd and 9th graders.

The surveillance system is a cooperative effort between the Department for Public Health and the University of Kentucky, School of Dentistry and is funding by the Oral Health Collaborative Systems Grant, Maternal and Child Health Bureau, HRSA.

c. Plan for the Coming Year

Once again, funding has been allocated to allow for the participation of twenty-three local health departments in the Kentucky Sealant Program with a total allocation of $ 184,000 through State General Fund dollars.

Kentucky's Fluoride Varnish program will continue, with allocations of $ 128,000. Allocations per local health department vary based on funding used the previous year. Local health departments are reimbursed at $ 5.00 per service and provided the fluoride varnish packets at no charge. This funding continues to be provided through Kentucky's Tobacco Settlement Dollars.

Kentucky's Children's Oral Health Surveillance System successfully underwent a pilot test, collecting data from over 400 children in counties adjacent to Fayette during the month of May 2005. Data is collected using a PDA (Personal Digital Assistant) and input by dental screeners at the time of the screening. To calculate the BMI, height and weight are also collected at the time of the screening. At the end of the day, the PDA is downloaded into a secure server at the University of Kentucky College of Dentistry.

Next steps include the development of reports which will provide screeners and oversight staff regular updates as to the number of children screened, oral health status and barriers to care. These reports will be under development during Summer and Fall 2005. Screenings will continue to complete the required sample during Fall 2005.

Finally, Kentucky's Oral Health Strategic Plan will be completed during Summer 2005 and published soon thereafter. The development of this plan has taken approximately one year, with input sought from over one hundred citizens across the state; from Pikeville to Paducah. With initial input via a website and subsequent participation in a meetings held in Lexington, volunteers divided into six workgroups (Partnerships and Collaborations, Public Education, School-Based Collaboration, Economic Development, Prevention, Workforce, Funding and Advocacy) and drafted goals, objectives and activities for each workgroup topic. Additionally, the following mission and vision statements resulted:

Mission Statement: Assure Oral Health for Kentucky!

Vision Statement: Healthy Kentucky Smiles: A Lifetime of Oral Health

Workgroups will continue meeting annually and will next focus their efforts on achieving some of the objectives stated by their committee. Several tasks have already been undertaken, including a Dental Workforce Study and plans to allow foreign-trained dentists to practice in Kentucky given the successful completion of several training requirements.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	6.7	6	6	5.9	5.9
Annual Indicator	6.4	5.3	3.9	5.3	5.8
Numerator	49	44	30	41	44
Denominator	771484	822878	770240	771987	758985
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.8	5.8	5.8	5.7	5.7

Notes - 2002

Data for 2002 is not available and will not be available until spring/summer of 2004. 2001 Data is still provisional. For this reason, annual performance objectives have not been altered. We would prefer to wait until 2001 data is final.

a. Last Year's Accomplishments

General Program Information - Motor Vehicle Deaths

Kentucky programs offering primary and prevention services with the goal to reduce child deaths are Well Child, HANDS, WIC, Child Fatality Review and Injury Prevention, the Kentucky SAFE KIDS Coalitions and Chapters, Child Abuse and Neglect Prevention and the Healthy Lifestyle Education program.

The rate of transportation related Kentucky child deaths remains unacceptable in that the rate is more than twice that of the national rate. Kentucky 2002 data for motor vehicle injury deaths reflected that its rate of 11.0 exceeded twice that of the 4.2 under age 16 national rate. Kentucky State Police (KSP) announced that it had observed a higher increase in traffic deaths for all ages during 2003 and 2004, than seen in 30 years.

Two specific efforts by the Maternal and Child Health Branch to reduce motor vehicle injury related child deaths include state and county Safe Kids Coalitions and associated chapters, and prevention measures identified through the Child Fatality Review Program. By meeting specific criteria, the Safe Kids Coalitions and chapters receive national grant funds to assist in fully implementing the "Buckle That Child" program. This program operates an 800 number for citizens to report Kentucky drivers who are noted driving with children unbuckled. Information on the importance of securing children and wearing seat belts is mailed to that driver. The funding provides safety seats for low income families. The second effort involves a General Motors and National Safe Kids Campaign partnership to purchase vans equipped to perform safety seat checkup. The Department of Public Health partnered with Kentucky Safe Kids and the Kentucky Department for Transportation (DOT) and the Governor's Drive Smart Program to implement these efforts.

Local Safe Kids Coalitions throughout the Commonwealth provide regular child passenger safety events supported by grant funding from the National Safe Kids Organization. The KSP and the DOT received a National Highway Traffic Safety Administration (NHTSA) grant to provide car and booster seats for Kentucky children. The Kentucky Injury Prevention and Research Center (KIPRC) received a grant to purchase high back boosters for Kentucky's Children.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuation of Kentucky Safe Kids Coalition and local Safe Kids Coalitions			X	X
2. Enhancement of Child Fatality Review to increase local review teams.				X
3. Injury prevention training within HANDS Home Visitiation Curriculm			X	X
4. Collaboration with KY Injury Prevention Research Center at the University of Kentucky				X
5. Participation in Governor's Drive Smart Team including safety seat checkups and other safe driving initiatives.			X	X
6. Collaboration with Coordinated School Health for physical activity brochures including safety information.			X	X
7. Publication of the annual Child Fatality Review Report.				X
8.				
9.				
10.				

b. Current Activities

Motor vehicle related child deaths increased from a rate of 3.9/100,000 in 2002 to 5.8/100,000 in 2004.

DPH and the State Child Fatality Review Team continue to support the development of injury prevention coalitions and local child fatality review teams assisted by the local health departments.

Additionally, the Division of Adult and Child Health Improvement (ACHI) supports and partners with the Pediatric and Adolescent Injury Prevention Program at the University of Kentucky. ACHI also partners with the Kentucky's Drive Smart Team to provide child safety seat

checkups and other safe driving initiatives aimed to reduce deaths to all Kentucky children under age 18.

Kentucky outcomes regarding reductions of child traffic related deaths indicate that additional components are needed to significantly reduce these fatalities. Previous research has identified three major injury prevention tools: 1) Education; 2) Product modification, such as improved safety features in automobiles; and 3) Legislation. Of the three, legislation is the most influential in reducing childhood injuries. In the past three Kentucky legislative sessions bills were introduced to modify existing or to related child transportation and safety but were unsuccessful. Bills for the 2006 Kentucky legislative session are now being prepared.

c. Plan for the Coming Year

Kentucky will continue to work with current partners to seek improvement in this performance measure.

The Kentucky Child Fatality Review (CFR) Annual Report analysis critical data in all areas of child death and supports recommendations to the Governor and the legislature.

The child fatality review (CFR) and injury prevention program emphasizes services for Kentucky children under age 18. Its mission is to reduce child health and life threatening conditions and injuries, most of which are preventable. All of Kentucky's 120 county Local Health Departments participate in child injury and death prevention education and behavior change activities. Grief counseling during a family's time of bereavement is offered. Seventy percent of the Kentucky's 120 counties voluntarily have organized local child fatality review teams aimed at preventing future child death. During 2004, the CFR state team initiated studies of child death prevention systems related to data, education, local child death review, legislation and financial support. These reviews include transportation associated injuries, infant suffocations, homicides, suicides and drug abuse. MCH publishes a child fatality review annual report to identify fatality and injury trends and provide prevention recommendations to reduce the morbidity and mortality rates of Kentucky children.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	54	55	55	56	56
Annual Indicator	54.2	55.2	56.5	56.5	58.0
Numerator	26521	27600	31075	31075	31900
Denominator	48931	50000	55000	55000	55000
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective	58	58	60	60	62

Notes - 2002

Data for 2002 is not yet available.

a. Last Year's Accomplishments

The Nutrition Services Branch and the University of Kentucky Medical Center held a Breastfeeding Conference on September 15, 2004. The conference targeted physicians, nurses, dietitians and other public and private health care providers. One of the conference speakers provided information concerning the link between chronic disease and breastfeeding.

The National Ad Council and the Office for Women's Health have created a Breastfeeding Ad Campaign. The State WIC Staff and the Breastfeeding Grantees and Steering Team will help promote the media campaign across the state.

Funding from the Centers for Disease Control Obesity Grant have been used to provide materials and education on breastfeeding role to reduce obesity and chronic disease across Kentucky.

Promotions for World Breastfeeding Week August 1-7, 2004 included a Governor's proclamation, news release information and materials mailed to the local health departments for local distribution.

The Loving Support Grant Trainings were accomplished by April 30, 2004. All agencies were provided with 3 breastfeeding videos, the book Medications and Mothers Milk, and Loving Support posters and information. Community partners were invited to the training and provided the same materials. Radio PSAs across the state promoted breastfeeding and support for working moms. Single User Electric Breast Pumps were ordered and distributed to each agency. The number distributed was based on the number of breastfeeding women enrolled in the WIC Program.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support of WIC Breastfeeding Grantees for breastfeeding promotion in their communities.			X	X
2. Breastfeeding Coalition building.			X	X
3. Training to local hostpital and providers.				X
4. Promotion of August WOrld Breastfeeding Week				X
5. Participation in National Breast Feeding Campaign.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Breastfeeding promotion activities include continued funding for breastfeeding grantees

positions to:
•Promote breastfeeding for the agency & surrounding counties.
•Develop breastfeeding billboards in Pike & Boyd Counties, Purchase & Green River Districts.
•Co-sponsor a Rock & Relax Room for the KY State Fair through the effort of Louisville Metro Health Department & Baptist East Hospital.
•Sponsor Mobile "Mother Nurture" Rooms in Boyd County, Cumberland Valley, Three Rivers & Purchase Districts. These rooms are used at local county fairs, concerts & other community activities to provide mothers a comfortable & safe place to nurse. Buffalo Trace District Health Department has developed their own Mother Nurture Room based upon the ideas from the Breastfeeding Grantee sites.
Another breastfeeding promotion activity to increase breastfeeding rates includes:
•A Breastfeeding Room was completed in the CHFS for staff and visitors to have a clean & quiet environment to pump.

Awareness activities that promote incidence & duration of breastfeeding include methods to:
• Develop & continue 7 Breastfeeding Coalitions. These provide opportunities for health professionals & peers to share ideas & support breastfeeding mothers in their community.
• Provide breastfeeding conferences to offer continuing education opportunities for health professionals. In May 2004, a three day breastfeeding training was provided by the Nutrition Services Branch and funded through the CDC Nutrition, Physical Activity and Obesity Grant. Approximately 80 people attended this training on the latest evidenced based practice to support breastfeeding. Three additional Breastfeeding Conferences are planned for 2005 & a session on Breastfeeding and the Prevention of Chronic Disease will be provided at the DPH Public Health Practice Summit.
•Provide breastfeeding education materials and promotional items to local doctor's offices & hospitals.
•Develop five new posters promoting breastfeeding by the Loving Support Breastfeeding Steering Team.
•Provide a Breastfeeding Resource Guide for health care professionals in both print & on the WIC website.
•Maintain & develop fruit, vegetable & candy slogans that promote breastfeeding to be used as an entry into health professional's office sites.
•Provide Advantages of Breastfeeding display boards to 80 sites.

Breastfeeding support activities include opportunities to:
•Offer electric and manual breast pumps for mothers who are returning to school or work.
•Maintain a rental program for hospital grade breast pumps for mothers and babies separated due to illness.
•Develop and expand a Breastfeeding Peer Counselor Program in four pilot sites across the state. The local breastfeeding coordinators will hire and train peer counselors for these pilot sites. The peer counselors will make contact with pregnant women who have an interest in breastfeeding and continue to provide support and encouragement to the mother after delivery.

c. Plan for the Coming Year

The Healthy People 2010 Objectives for breastfeeding are the goal for the Kentucky Breastfeeding Program. Efforts on awareness, promotion and support will continue in efforts to increase incidence and duration of breastfeeding. These activities will include the following:

• Continuation of funding for ten Breastfeeding Grantees;
• Revision of education materials to meet the needs of breastfeeding women in English and Spanish;
• Provision of electric and manual breast pumps for women returning to work or school;
• Continuation of Breast Pump Rental Program;

• Provision of breastfeeding promotion posters in Spanish;
• Expansion of Peer Counselor Program into other sites;
• Provision of breastfeeding continuing education;
• Development of worksite wellness policies to promote and support breastfeeding;
• Development of legislation to protect and support breastfeeding mothers;
• Continue to follow and update the Breastfeeding State Plan;
• Plan activities and continue to work with the Kentucky Nutrition and Physical Activity State Action Plan;
• Completion of bibliographies concerning breastfeeding and prevention of chronic diseases.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	75	80	98	98	99
Annual Indicator	74.4	90.1	98.9	99.3	99.4
Numerator	38428	45799	49233	50643	51849
Denominator	51672	50827	49783	51008	52172
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	99	99	99	99	99

Notes - 2002

For the report due on July 15, 2003 , the denominator used for this measure is the number of UNHS forms received during the state fiscal year (7/1/01-6/30/02), and does not reflect total number of births in Kentucky. Information will be revised using the number of births later this year when that information becomes available from the state's Vital Statistics. Note that KY regulations for UNHS require only those hospitals that have at least 40 births per year to perform and report newborn hearing screens. This means a small number of infants born at home or in a non-reporting hospital will not be included in the report. It is not anticipated that the performance indicator will rise above 98% as some families do choose not to have the screening and, more often, hospital screening equipment may not be functioning so some infants are scheduled for screening as soon as possible after discharge.

Notes - 2003

For the report due on July 15, 2004, the denominator does not reflect total number of live births in Kentucky. The number reflects the total number of newborn hearing screening reports received from those hospitals mandated to provide a report on all newborns prior to discharge during the 2003 calendar year. Kentucky regulations require only those hospitals that have at

least 40 births per year to perform and report newborn hearing screenings. This means infants born at home or in a non-reporting hospital are not mandated to be screened. It is not anticipated that the performance indicator will rise above 99% for those newborns who are required to be screened due to some families choosing not to have the screening and more frequently because hospital screening equipment may not be functioning prior to the infant's discharge. If the newborns that are not required to be screened are included in the denominator, the target performance indicator is not expected to exceed 94%. Between 1999 and 2003, hearing screening reports were provided for an average of 89.96% of all live births; the percentage in 2002 was 91.52% and the provisional percentage in 2003 was 93.71% of all live births.

a. Last Year's Accomplishments

The Universal Newborn Hearing Screening staff has provided numerous presentations to a variety of audiences focused on dissemination of information about the Commission's program, collaboration with the medical home, coordination of services from the hospital hearing screening through diagnostic audiology to warranted early intervention services, and education future pediatricians, general practitioners and audiologists.

The presentations included:

- May 23, 2003 -- A collaborative presentation with the American Academy of Pediatrics, Chapter Champion for Newborn Hearing Screening, Dr. Dan Stewart, at Kosair Children's Hospital Grand Rounds. The audience included practicing physicians, residents and first and second year medical students, audiologists and speech --language pathologists. This was the first Telehealth Network presentation in the state of Kentucky and was simultaneously broadcast statewide with the ability for statewide participants to interact with the presenters.
- Nov. 2003 -- Infant Toddler Institute. Multiple presentations were provided by UNHS staff as requested by the oversight committee for the conference. The audience included Part C providers, nurses, parents, audiologist, speech-language pathologists, day care and pre-school staff. Topics presented included Overview of Audiology; What To Do: When working with a Child Identified as Deaf or Hard of Hearing; Brain Development in the First Year of Life: and Learning to Sign.
- May 20, 2004 -- Presentation to the Au. D. class at the University of Louisville. Second and third year students in Audiology were given a historic review of Universal Newborn Hearing Screening, State and National guidelines pertaining to the screening, evaluation and warranted intervention and recommended reporting procedures; and audiological and brain development in the infant through age 1 year.
- Led the development of a series of Risk Presentations for Low Incidence Impairments including Deaf and Hard of Hearing, Blind and Deaf/Blind with community partners. The series is to be presented to second year medical students at both the University of Louisville and the University of Kentucky. To date, the Power Point draft presentations have been presented to U of K students in the Department of Special Education. UNHS staff is presenting the Risk Factors related to Deaf and Hard of Hearing series.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
2.				
3.				
4.				

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Commission has completed the transfer of the UNHS database into the Commission's web-based care coordination system (CUP). A parallel activity underway is the development of systems capacity for web-based entry of the Hearing Screen Report Form by birthing hospitals. Once these systems are fully operational, the Commission plans to develop web-based reporting for audiology providers to notify the Commission when infants, receive the recommended diagnostic follow-up evaluation.

There have been multiple presentations by UNHS staff since May 2004. Staff presented a total of 5 Presentations at the National Early Hearing Detection and Intervention Conference in Feb. 05 in Atlanta, GA; one presentation to the Directors of Speech and Hearing Programs in State Health and Welfare Agencies in Feb. 05, Atlanta GA.; Presentation at the Early Childhood Educator's conference, Feb. 05; Just In Time presentation in May 05, Minneapolis, MN; as well as numerous presentations approximately 10 a month to a variety of audiences including families, physicians, hospital staff, audiologists, early interventionists, educators and other allied health care workers.

c. Plan for the Coming Year

Continue above.

In the state calendar year, 51,849 infants were screened prior to discharge from hospitals required to perform and report newborn hearing screening. During the same period, there were 52,172 live births reported by those hospitals mandated to provide a report on all newborns prior to discharge. The percentage screened was 99.28% of all live births at hospitals that have at least 40 births per year and are required to perform and report newborn hearing screening.

It is not anticipated that the performance indicator will rise above 99% for those newborns who are required to be screened due to some families choosing not to have the screening and more frequently because hospitals screening equipment may not be functioning prior to the infant's discharge.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance	9	8	7	6	6

Objective					
Annual Indicator	9.9	6.9	8.3	8.1	8.1
Numerator	98486	72907	85000	85000	85000
Denominator	994818	1049353	1018000	1048000	1048000
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6	6	6	6	6

Notes - 2002

Data supplied from the US Census Bureau Report.

Notes - 2003

Data supplied by the U.S. Census Bureau Report

Notes - 2004

Data supplied from the US Census Bureau Report.
Data reported is from 2003. 2004 Data was unavailable.

a. Last Year's Accomplishments

In 1998, it was estimated that 13.3% of Kentucky's children were uninsured. In 1999 this estimate decreased to 9.9%. Over the next few years, the estimate for uninsured children continued to decline, to 6.9 in 2001. In 2002 and 2003 the U.S. Census Bureau estimation shows an increase. This may be due to cut back in outreach efforts.

All uninsured children under age 19 in families with incomes below 200% of the Federal Poverty Guidelines are now eligible for health insurance coverage either through KCHIP of Medicaid.

Kentucky implemented the KCHIP program in multiple phases. The first phase began July 1, 1998, as an extension of Medicaid coverage to children 14 through 18 years of age who were in families at or below 100% of the Federal Poverty Level (FPL). The second phase of KCHIP began on July 1, 1999. Medicaid was expanded to cover eligible children from age one through 18 years who did not already have health insurance and whose family income fell at or below 150% FPL. The third phase began in November 1999 as separate insurance program. This phase covers children whose family incomes are 151% FPL and up to 200%. The separate insurance program offers the same benefits as Medicaid, except for non-emergency transportation and Early Periodic Screening Diagnosis and Treatment (EPSDT) special services. Eligibility is determined by the Department for Community Based Services (DCBS). KCHIP children use the same health care providers as Medicaid and are served through the same service delivery systems as Medicaid.

KCHIP members enrolled in either Passport or KenPAC are required to select a Primary Care Physician (PC). PCPs or Primary Care Case Managers are responsible for the coordination of medical services for children enrolled in KCHIP. The purpose for these medical homes is to provide each child with a health care professional who understands the unique needs of the child.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

	Pyramid Level of

Activities	Service			
	DHC	ES	PBS	IB
1. Continued support for Medcaid/KChip enrollment				X
2. Collaboration with Medicaid/KCHIP program initiatives.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Eligibility is determined by the Department for Community Based Services (DCBS). KCHIP children use the same health care providers as Medicaid and are served through the same service delivery systems as Medicaid.

Jefferson County and the seven surrounding counties are where KCHIP services for children are covered through Passport Health Plan. Children residing in the other 112 counties are served through KenPAC, a Primary Care Case Management (PCCM) program.

KCHIP members enrolled in either Passport or KenPAC are required to select a Primary Care Physician (PC). PCPs or Primary Care Case Managers are responsible for the coordination of medical services for children enrolled in KCHIP. The purpose for these medical homes is to provide each child with a health care professional who understands the unique needs of the child.

The Division of Adult and Child Health Improvement through partnership with the Division of Local Health Operations and the Department for Medicaid Services have been working to provide outreach, education and referral for the Kentucky Children's Health Insurance Program but this effort has been reduced.

All uninsured children under age 19 in families with incomes below 200% of the Federal Poverty Guidelines are eligible for health insurance coverage either through KCHIP or Medicaid.

Current KCHIP enrollment data as of March 2001 - 54,183.
Cumulative Enrollment Data -- 77,532

Current KCHIP enrollment data as of March 2002 -- 51,368
Cumulative Enrollment Data -- 133,635

Current KCHIP enrollment data as of March 2003 -- 50,531*
Cumulative Enrollment Data -- 161,959

KCHIP enrollment data as of March 2004 - 48,776
Cumulative Enrollment Data - 187,126

c. Plan for the Coming Year

The Division of Adult and Child Health Improvement through partnership with the Division of Local Health Operations and the Department for Medicaid Services will continue to provide outreach, education and referral for the Kentucky Children's Health Insurance Program.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	62.5	63.5	64.5	76	90
Annual Indicator	68.1	77.2	75.4	90.7	73.3
Numerator	264663	328829	321036	390982	326826
Denominator	388631	425820	425931	430870	445923
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80	80	82	82	82

a. Last Year's Accomplishments

Medicaid and KCHIP eligibility guidelines state that any child age 18 and under is eligible for either KCHIP or Medicaid if their family income is below 200% of the federal poverty guidelines. Using these criteria to define the eligible population, it is estimated that there were approximately 508,000 children eligible for one of these programs. This includes all children below 200% of poverty regardless of their insurance status; that is, some will be enrolled in Medicaid or KCHIP, some will be uninsured and some will have a private insurance policy. The data used from this estimate comes from the Current Population Survey and the Kentucky Health Insurance Survey. - Mike Clark, Ph.D.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Collaboration with Medicaid to access needed data for MCH programs.				**X**
2. Continued support for Medcaid enrollment and services				**X**
3. Collaboration with Medicaid program initiatives.				**X**
4.				
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities

Efforts to increase Medicaid providers are ongoing and should ease with the fee-for-service model used by the KenPAC program. Currently KenPAC serves approximately 254,000 enrollees in 102 Kentucky counties. There are about 1,500 physicians at nearly 1000 clinic and office sites participating in the program in Kentucky and bordering states.

In 2000, 68.1 percent of children potentially eligible for Medicaid actually received a service. In 2001 and 2002, the total for this measure continued to increase (77.2% and 75.4% respectively) and in 2003, enjoyed a substantial increase, to 90.7%.

c. Plan for the Coming Year

Kentucky's State Systems Development Initiative (SSDI)Grant is currently funding Kentucky's initial effort in linking various MCH data sets. While birth and death records will be the first sets linked, the linkage of Medicaid eligible data to both birth and death records will be a high priority. With this information, we can identify children who should be receiving services but who may not currently be in the system.

Many of the programs within the ACH Division currently import Medicaid data and link with records in their respective databases. But no truely integrated electronic linkage system exists between Medicaid and MCH Data systems.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	1.2	1.5	1.3	1.3	1.3
Annual Indicator	1.5	1.5	1.7	1.7	1.5
Numerator	858	812	902	930	801
Denominator	55969	54114	53956	55413	52134
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual					

Performance Objective	1.3	1.3	1.2	1.2	1.2

Notes - 2002

Data for 2002 is not available and will not be available until spring/summer of 2004.

a. Last Year's Accomplishments

General Information: Low Birth Weight

General risk factors for very low birth weight and low birth weight include poor nutrition, smoking, substance abuse, infections, lack of oral health and lack of access to prenatal care. Maternal risk factors include diabetes, hypertension, anemia, pulmonary disease, cardiac disease, infections (vaginal and periodontal), chronic lead exposure and abnormal reproductive anatomy.

Several Kentucky programs under the KIDS NOW! Early Childhood Initiative address the risk factors of low and very low birth weight. The HANDS home visiting program allows more first-time mothers to access prenatal care and services that will enhance their birth outcomes. Kentucky's Folic Acid Campaign increased the number of women of childbearing age who regularly ingest folic acid and decrease the number of infants born with neural tube defects.

Substance abuse prevention and treatment for pregnant and postpartum women are now covered through Medicaid. Local health departments and comprehensive care centers are now teaming up to identify substance-abusing prenatal patients early in the pregnancy. Other programs that positively impact this problem include tobacco cessation in the maternal population, WIC, teen pregnancy prevention, family planning, and prenatal.

Finally, Kentucky's network of genetic outreach clinics throughout the state continue to bring excellent genetic evaluation services to patients referred by local health departments and private providers. A state genetics plan and several statewide meetings for those interested in furthering genetic services within Kentucky have occurred during the past year as the Division for Adult and Child Health received a State Genetics Grant from HRSA in 2000, totaling $ 75,000 for each of two years.

Data for 1999 shows a decline from the previous year; from 1.7 in 1998 to 1.5 in 1999.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Emphasis on low birthweight and prematurity during local health department review process.				X
2. Collaboration with Kentucky Perinatal Association and the March of Dimes Foundation.				X
3. Continuation of Substance Abuse Cessation project funding through KIDS NOW!		X	X	X
4. Continued with with youth through programs including PSI and Abstinence Education.		X	X	X
5. Folic Acid Supplementation through local health departments and community campaigns.	X		X	
6. Contiued support of the Kentucky Birth Surveillance Regisrty to identify Congential anomalies.			X	X

7. Contracting through Kentucky teriary centers for state wide genetic services.	X			X
8. Smoking Cessation initiatives in local health departments.		X		X
9. Continued involvement and support of the Prematurity Campaign Committee with the March of Dimes.			X	X
10.				

b. Current Activities

Data for 2000 and 2001 remains steady for the measure at 1.5 percent.
There was a slight increase in very low birth weight to 1.7% in 2002.

In CY 02, a contrast group of first-time parents not participating in the voluntary home visitation program, HANDS, was compared with participating families. The HANDS program saw 13% fewer low birth weight infants and 29% fewer very low birth infants.

To "jump-start" local efforts to combat the problem of low birth weight, this measure was one of three maternal and child health measures selected for programmatic emphasis during the FY04 budget year in cooperation with local health departments. Activities known to reduce low birth weight, such as presentation of prenatal classes for families were recommended. These were listed and local health departments selected appropriate activities for their community, using Title V funding.

The problems of both prematurity and low birth weight are being aggressively addressed in Kentucky. In June 2003, funding was allocated by the Greater Kentucky Chapter of the March of Dimes to support the Kentucky Perinatal Association (KPA) Conference presentation of "Summit on Prematurely; Caring for Our Smallest Citizens".

This conference is traditionally attended by those working in the field of perinatology and is an excellent opportunity to reach physicians and neonatal nurses from across the state. Topics such as "Managing High Risk Pregnancies to Prevent Prematurity" by John O'Brien, M.D., "Focus on Prematurely in the Commonwealth of Kentucky" by James S. Davis, M.D. and "Premature Birth - The Answers Can't Come Soon Enough" by Karla Damus, PhD, M.S.P.H., R.N. (March of Dimes National Foundation), and "Update on New Aggressive Therapies in Nutrition for Preterm Infants" by David H. Adamkin, M.D. were included within the Summit Agenda.

In June of 2004 the KPA annual meeting: Summit on Prematurely, focused on two major aspects of health care practice as it relates to prematurely: care of the mother during pregnancy and care of the mother and infant in the event of premature birth.

The March of Dimes in collaboration with the Department for Public Health has partnered with other state professional and community stakeholders to establish a Kentucky Prematurity Steering Committee (KPSC) which met initially in August 2003 and throughout 2004 to promote statewide community partnerships and to assure continued and strengthened preconceptional and prenatal health education in Kentucky to reduce the rate of preterm births. The March of Dimes and the Kentucky Department for Public Health sponsored a one-day Prematurity Summit in November 2004 targeting health care professionals. There were 170 participants at the meeting which focused on the causes of prematurity, the impact on children born prematurely, and prevention/intervention activities. The KPSC continues to meet in 2005.

Programs such as HANDS will continue to work to assure that women receive early and adequate prenatal care.

c. Plan for the Coming Year

The March of Dimes is planning a second Prematurity Summit in November 2005. This summit will target community leaders in a morning session and health professionals in the afternoon. Topics included in the summit will highlight the impact of prematurity in Kentucky and evidence-based practice to reduce the number of preterm births. The Folic Acid Partnership will continue to have objectives related to prematurity addressed to the three audiences of health professionals, community and mass media. The members of the partnership are providing information about the signs and symptoms of preterm labor along with folic acid education. The Kentucky Perinatal Association is also developing a web-based educational program entitled "Health Professional Education on Prematurity" which will be available with continuing education credits to all health professionals in Kentucky.

MCH supports maternity care services in health departments with the goal of reducing maternal and infant mortality and decreasing the need for high cost neonatal intensive care. The Prenatal program assures access for low income women to health screening and counseling prior to conception, outreach and follow-up, nursing and nutrition counseling, preterm birth prevention screening and education, routine laboratory tests, routine radiology exams, delivery, post partum care, and home visits. Maternity services were provided to 8,655 low income women in FY 04. MCH collaborates with March of Dimes to assist in their 5 year, $75 million research awareness and education campaign aimed to decrease premature births and to help families have healthier babies.

Folic Acid supplementation is provided to all women of childbearing age along with education regarding the prevention of neural tube defects. IN FY 04, 87,485 women received folic acid supplementation and counseling through Local Health Departments. MCH participates in the Kentucky Folic Acid Partnership, which promotes statewide awareness and education on folic acid and the benefits to women of childbearing age in the reduction of neural tube defects. The partnership consists of 81 individual members and 70 agencies, organizations and businesses. The Partnership had a total of 548 statewide activities reaching 1,915,139 participants in FY 04.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	8.3	8.6	8.5	8.3	8
Annual Indicator	8.7	6.1	6.8	6.8	9.6
Numerator	25	18	19	19	27
Denominator	289004	296014	278886	280816	280929
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective	7.9	7.9	7.9	7.8	7.8

Notes - 2002

Data for 2002 is not available and will not be available until spring/summer of 2004.

a. Last Year's Accomplishments

The Kentucky youth suicide rate increased from 6.8/100,000 in 2003 to 9.6/100,000 in 2004. Programs have been developed to address this very important issue.

Activities have included monthly educational communications with youth and those serving youth, including government agencies, schools, the faith community, health care providers; local television and radio broadcasts of interviews with people whose lives have been affected by suicide; and information distributions for youth, parents, citizens and health professionals about risk factor identification associated with suicide support service referrals.

Senate Bill 148 was passed in the 2004 legislation session, authorizing the Kentucky Suicide Prevention Workgroup as a statewide oversight group for suicide prevention.

A collaborative contract was initiated in 2004 between the Department for Public Health and the Department for Mental Health/Mental Retardation (MH/MR) to increase efforts in reducing youth suicides. MH/MR hired a new suicide prevention program coordinator who participates on the Kentucky Child Fatality Review (CFR) State Team. The Department for Public Health, Maternal and Child Health Branch Manager and the Kentucky CFR and Injury Prevention Program Administrator serve on the Suicide Prevention Workgroup.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaboration with the Department for Mental Health and Mental Retardation on Suicide Prevention Workgroup and Child Fatality Review Team.				X
2. Increased public awareness of suicide through media campaign				X
3. Identification and Coordination of Resources.				X
4. Identification of intervention options and training resources. Suicide Prevention Conference Sept 2005.				X
5. Enhance Mental Health Initiatives through KIDS NOW!				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Suicide Prevention Work Group and the CFR State Team each meet minimally on a quarterly basis, with varying standing committees and as needed subcommittees meeting intermittently regarding assigned projects. The Suicide Prevention Work Group focuses on suicide prevention strategies for all age groups, whereas the CFR State Team focuses on suicide prevention for children under age 18.

The University of Kentucky Pediatric and Adolescent Injury Prevention Program of the Injury Prevention and Research Center applied for and was approved in 2004 for a Center for Disease Control (CDC) grant to participate in a 5-year study with the National Violent Death Reporting System. The study will focus on various analyses of confirmed suicides and homicides, as well as accidental firearm, drug overdose and hanging deaths that may have been suspected suicides or homicides.

c. Plan for the Coming Year

Kentucky, through the leadership of the Department for Mental Health and Mental Retardation, has developed a Suicide Prevention Plan. The Suicide Prevention Workgroup began meeting in March 2002, and eight members attended the SPAN Conference in Washington, D.C. in July of 2002. Formal goals adopted by the group are: 1) To increase public awareness of suicide as a preventable public health problem; 2) To identify and coordinate resources, intervention options, and training opportunities within the state; and 3) To evaluate the methodology and impact of the group's efforts and the available resources.

The Department for Public Health provides support to the Kentucky Department for Mental Health and Mental Retardation to increase efforts in reducing youth suicides. MCH staff are members of the Suicide Prevention Workgroup and MHMR staff are members of the State Child Fatality Review Team. The groups will sponsor Suicide Prevention Week, September 4-10, 2005 as part of an educational media campaign. A conference entitled "Suicide Prevention: It's Everybody's Business" will be held September 6-7, 2005 and "Palette of Grief" a post-conference experience will be held September 8-9, 2005. Both events will be held in Louisville. For more information about the conference or to obtain a copy of the Suicide Prevention Plan you may contact the Suicide Prevention Workgroup at their website at: http://mhmr.ky.gov/mhsas/suicidepreventiongroup.asp

The University of Kentucky Pediatric and Adolescent Injury Prevention Program of the Kentucky Injury Prevention and Research Center (KIPRC) initiated its 5-year study with the National Violent Death Reporting System in January 2005. Periodically during the study, KIPRC project representatives will share general trend information with professionals, especially with the Kentucky Suicide Prevention Work Group and the Kentucky Child Fatality Review State Team, making recommendations regarding improvement of prevention strategies.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance	69	60	60	60	61

Objective					
Annual Indicator	51.7	59.9	68.0	62.4	51.8
Numerator	444	585	613	580	415
Denominator	858	976	902	930	801
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	64	66	66	67	67

Notes - 2002

Data is not available for 2002 and will not be available until spring/summer 2004.

a. Last Year's Accomplishments

General Information: Neonatal Regional Care Delivery

Four Kentucky hospitals qualify as Level III Neonatal Hospital facilities, the University of Kentucky (Lexington), University of Louisville, Norton/Kosair (Louisville) and Suburban (Louisville). A total of 117 beds are licensed for care under the Level III designation. Additionally, 221 beds are licensed for care under the Level II designation; these hospitals are distributed throughout the state while the Level III hospitals cluster in the two major population centers; Louisville and Lexington.

Special Care Neonatal beds are licensed acute care beds located in hospital neonatal units that provide care and treatment of newborn infants through the age of 28 days, and longer if necessary.

The number of Level III Neonatal beds is determined by a calculation based on the total annual births in the state while the number of Level II Neonatal beds is based by a calculation using the number of total annual births to an area development district.
The Cabinet for Health and Family Services may determine that more Level III beds are necessary in order to allow for the presence of hospitals that provide a higher intensity of neonatal care than that provided by most hospitals due to a high percentage of neonatal patient referrals for specialized services such as open-heart surgery, transplants, etc.

The Office of Certificate of Need within the Cabinet for Health and Family Serivces is responsible for working with local hospitals and keeping standards consistent with the Guidelines for Perinatal Care, Third Edition, published jointly by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology.

In 2002, 68.0 percent of very low birth weight infants were delivered at hospitals licensed as Level III facilities in Kentucky. This was an increase over 59.9 percent in 2001.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. On-going training fro health professionals working with neonates.				X
2. Oversight by the Office of Certificate of Need and adherence of				

standards or care.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

68.0 percent of very low birth-weight infants were born at either Level III or Level II nurseries in 2002.
62.4 percent of very low birth-weight infants were born at either Level III or Level II nurseries in 2003.

Level II nurseries are being utilized more to care for at-risk infants since these nurseries are more geographically distributed across the state than Level III nurseries. Also, as more neonatologists are being trained, these professionals are going to rural Level II nurseries to care for these infants. Several local hospitals have excellent neonatal units that meet the need of women giving birth to very low birth weight infants in their areas.

c. Plan for the Coming Year

The Department for Public Health continues to monitor this measure and to work cooperatively with local hospitals to assure the care of these newborns. Due to the rural nature of many Kentucky counties, Level II hospitals will continue to support this process by delivering some of Kentucky's at-risk infants with selected conditions.

The Office of Certificate of Need within the Cabinet for Health and Family Services is responsible for working with local hospitals and keeping standards consistent with the Guidelines for Perinatal Care, Third Edition, published jointly by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	86	86.5	87	85.8	85.9
Annual Indicator	85.7	85.6	85.7	86.2	86.2
Numerator	47960	46321	46267	47741	47741

Denominator	55969	54114	53956	55413	55413
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	86	87	87	87	88

Notes - 2002

Data for 2002 is not available and will not be available until spring/summer 2004.

a. Last Year's Accomplishments

Preliminary data for 2001 and 2002 indicates a slight increase has been achieved (85.7%) in this performance measure. Data for 2000 and for 1999 indicated a very slight increase was achieved in this performance measure. In 2000 and 1999, 85.6 percent of Kentucky mothers received prenatal care in the first trimester as compared to 85.5 percent in 1998, 85 percent in 1997, and 83.8 percent in 1996.

At the local level, all local health departments have been certified in the Medicaid Presumptive Eligibility (PE) process to enable them to assist prenatal patients, who are eligible, to access temporary prenatal benefits at the time of the positive pregnancy test. PE is an eligibility tool adopted by Kentucky's Department for Medicaid Services to expedite a pregnant woman's access to needed outpatient prenatal services while their application for full Medicaid benefits is being processed.

Local health department staff continue to provide counseling to pregnant women on the importance of early entry into prenatal care at the time of their positive pregnancy test, and appropriate referrals such as first time pregnant moms to the HANDS Program. In addition, local health department staff will make an appointment or a referral for the pregnant women, to initiate early entry into prenatal care, as well as, assisting Medicaid eligible pregnant women to access services.

Some local health departments have paid for prenatal services, out of their community funds, for the uninsured pregnant women (i.e., the undocumented Hispanic population). This financial burden has been greater in some counties than in others. The Division of Adult and Child Health Improvement has attempted to alleviate some of this financial burden by allocating additional specified funds to the local health departments.

Kentucky's population has a high prevalence of smokers; in 2001, Kentucky led the nation in the total percentage of smokers (30.9%). Data from the Behavioral Risk Factor Survey (BRFSS) for 2001 found that 35.8% of women between the age of 18 - 44 smoke in our state. Data from the Kentucky Vital Statistics indicates a prevalence of 23.4% of women smoking during pregnancy and preliminary data for 2001 indicates no change. Preliminary data for 2002 from the Kentucky Vital Statistic files indicates a slight increase in women smoking during pregnancy (24.0%). Adverse health outcomes for the infants of pregnant women who smoke have been well documented; they include higher rates of SIDS and low-birth weight, just to name a few.

In response to this significant public health problem, Kentucky has implemented many programs to encourage all women of childbearing age, and the general population, to stop smoking. On a local level all health departments offer client smoking cessation interventions. The Tobacco Prevention and Cessation Program is focusing on reducing smoking and has introduced a OuitLine that began operation July 1, 2005.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support of maternity and prenatal services through the local health department funded by Title V.				X
2. Presumptive Medicaid eligibilty for pregnant women.		X	X	
3. Continuation of Substance Abuse Cessation project funding through KIDS NOW!		X	X	
4. Collaboration between Comprehensive Care Centers (Kentucky's mental health providers) and local health departments.				X
5. Smoking Cessation initiatives in local health departments.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Preliminary data for this measure has remained steady for 2002, with 85.7% of Kentucky's women receiving prenatal care in the first trimester. The percent of women receiving early prenatal care has increased steadily over the past five years. Funding from the Title V Block Grant, allocated to local health departments as unrestricted monies (to be used to support Title V Performance Measures) is often used to support prenatal services for local health department cliental.

As part of the Governor's KIDS NOW Early Childhood Development Initiative, the Substance Abuse Prevention Team in the Chronic Disease Branch is working in partnership with the Maternal and Child Health Branch to support a statewide effort aimed at increasing the health of all Kentucky babies by decreasing the use of alcohol, tobacco, and other drugs during pregnancy.

Components that comprise this initiative include:

- A Medicaid Benefit package providing a full continuum substance abuse prevention and treatment services to Medicaid-eligible women who are pregnant or postpartum up to 60 days.

- Substance abuse prevention and treatment services for non-Medicaid eligible pregnant women and women with dependent children.

- Outreach efforts aimed at better identifying pregnant and postpartum women in need of substance abuse prevention or treatment, and engaging in those services

- Collaborative efforts between local agencies and within the Mental Health prevention and treatment systems to help provide a full continuum of care to pregnant women in need of all types of services.

In the first two quarters of FY02, 169 pregnant women have been screened or referred, 225 have been assessed and 285 have entered prevention or treatment services as a result of this initiative. Additionally, funding for methadone treatment and transportation for narcotic addicted

pregnant women (including oxycontin) is provided. Individual incentives are offered for delivering a healthy baby and for remaining in the program.

Data through the third quarter of FY03 (based upon the state fiscal year of July 1st through June 30th) is: 5405 pregnant women screened or referred; 574 pregnant women receiving an assessment and 2104 pregnant women actually entered prevention or treatment services following a screening or assessment by the KIDS NOW project.

Data through the third quarter of FY04 is: over 6,000 pregnant women have been screened for substance abuse in health departments across the state using a research-based screening tool specifically designed for screening pregnant women for substance abuse risk in pregnancy (The 4P's Plus was developed by Dr. Ira Chasnoff of the Children's Research Triangle in Chicago. The screening tool asks about Present use, Past use, Parent's use and Partner's use.)

The KIDS NOW Substance Abuse and Pregnancy Initiative staff across the state has provided a substance abuse prevention and/or treatment service to 2,537 pregnant women.

c. Plan for the Coming Year

Continue utilizing the Presumptive Eligibility process to enable pregnant women to access prenatal care timely to enhance birth outcomes.

The number of Local Health Departments participating in the substance abuse cessation initiative has increased substantially in the past year (80 health departments have memorandum of Understanding (MOU) with their regional Comprehensive Care Centers to address prevention and treatment of substance abuse in pregnant women). Eleven of the forty health departments who do not have an MOU with their regional Comprehensive Care Center are working on the development of an MOU. According to the KIDS NOW Early Childhood Initiative Summary dated March 2004, over 2,500 pregnant women have received treatment and over 6,000 pregnant women have received prevention services from this program to date.

An article entitled "Smoking During Pregnancy in Kentucky; Placing Children At Risk", was written by DPH epidemiologists Tracey Jewell, MPH and Sara Robeson, MA, MSPH. In this article the prevalence of smoking in Kentucky's women of childbearing age was examined in detail, examining vital records and BRFSS data from the last decade. The relationship between smoking and adverse health outcomes for infants was examined, including the occurrence of low birth weight and SIDS deaths, using vital statistics data. The article was published in Kentucky's monthly publication, Epidemiologic Notes and Reports in July of 2003, which is widely read by local health department personnel, private providers and others. An update on this article will be done by Tracey Jewell and Sara Robeson for Epidemiologic Notes and Reports.

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Percent of women of childbearing age taking folic acid regularly.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	2000	2001	2002	2003	2004

Performance Data					
Annual Performance Objective	45	47	45	45	45
Annual Indicator	41.7	39.6	40.4	NaN	45.6
Numerator	320248	316816	321823	0	358930
Denominator	767983	800042	797075	0	787269
Is the Data Provisional or Final?				Provisional	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	45	45	45	45	46

Notes - 2003

There is no data on folic acid consumption for 2003 as it was not included on Kentucky's Behavioral Risk Factor Survey.

a. Last Year's Accomplishments

Folic Acid - General Information

The importance of folic acid is stressed for both primary and preventive services for women and infants for children via Family Planning Services, Nutrition Services, Adult Health, WIC, Genetics, Healthy Lifestyle Education and the Birth Surveillance Registry. The Folic Acid Module was included in the Kentucky Behavior Risk Factor Survey for 1997, 1999, and 2000, and 2001.

The Division of Adult and Child Health Improvement engages in a folic acid campaign with the March of Dimes Birth Defects Foundation and forty-five interested partners through activities of the Kentucky Folic Acid Partnership. Additionally, free folic acid supplementation and counseling for low-income women of childbearing years is provided as a component of KIDS NOW! Kentucky's Early Childhood Development Initiative, and was included as part of the early childhood development package passed during the 2000 legislative session. The supplement program is provided through every county health department in Kentucky.

During 1999, 39.3 % of women were taking folic acid regularly, an increase from 36.2 % in 1997.
2000 BRFSS data shows that 41.8% of Kentucky women of childbearing age are currently taking folic acid regularly. In 2001, 39.6% of women were reached with the folic acid message and in 2002, 40.4% were reached. No data was available for 2003 as this question was not included in the survey.

In FY02, 110,623 women have received folic acid supplements and nutritional counseling. 862,500 Kentuckians were reached with the folic acid message through community and professional events and thousands more thought radio, TV and news articles. During the week of Mother's Day, restaurants statewide distributed 400,000 tray liners with the folic acid message.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

	Pyramid Level of

Activities	Service			
	DHC	ES	PBS	IB
1. Continued support of Folic Acid Supplementation Program at the LHD level		X		X
2. Continued coordination of Kentucky's Folic Acid Partnership		X		X
3. Incidence and Prevalence rates for Neural Tube Defects through the Kentucky Birth Surveillance.				X
4. Collaboration with the March of Dimes Birth Defects Foundation and Kentucky Spina Bifida Association				X
5. Genetic Clinics throughout the state via contact with University of Kentucky and Louisville.	X	X		X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During FY03, in addition to the 120 county local health departments, folic acid tablets and counseling are now being provided at six state universities. 85,736 women have received folic acid tablets and counseling. 32,403 participants were reached in 395 statewide folic acid activities from July 2002 - July 2003 through the efforts of the Folic Acid Partnership.

As of January 2004, the Kentucky Folic Acid Partnership has 75 individual members representing 66 agencies, organizations, and businesses. 45,887 women have received folic acid services from July-December 2003 and a CDC folic acid module was added to the 2004 BRFSS to report knowledge of benefits and consumption of folic acid among Kentucky women 18-44.

Given the success of the Folic Acid Workgroup, the group decided to expand their vision from folic acid awareness and consumption to the reduction of preterm births. As referenced in the opening section of the Title V Block Grant Narrative, preterm and low-birth weight births are quickly increasing in Kentucky as they are throughout the nation. The March of Dimes Birth Defects Foundation has been a supportive partner throughout the folic acid campaign and are now placing a new emphasis on preterm and low birth weight births. This group is now spearheading the Prematurity Campaign, chaired by Steve Davis, MD; Deputy Commissioner of the Department for Public Health.

Neural tube defects (NTDs) are ascertained through multiple data sources in Kentucky utilizing active and passive case ascertainment. The rate for all NTDs including spina bifida, anencephaly and encephaloceles was 12.7/10,000 live births and stillbirths in 1996. A decline in NTDs occurred until 1999 when the rate was 5.7/10,000 live births and stillbirths. An increase was noted in 2000 to a rate of 9.4/10,000 live births and stillbirths. In 2001, the rate declined to 5.3/10,000 live births and stillbirths. The rate increased to 5.9/10,000 live births and stillbirth in 2002 and 6.1/10,000 live births and stillbirths in 2003. Overall, from 1996 to 2003 there has been a 48% reduction in the number of children in Kentucky affected by these serious birth defects. Geographical mapping of this data has identified the areas of the state with the highest rates.

c. Plan for the Coming Year

In 2005, the BRFSS will again include folic acid supplementation information. Kentucky will continue to work with local health department partners to provide folic acid tablets and awareness/education to all women of childbearing age in the Commonwealth. Additionally, the partnership will continue between the Kentucky Birth Surveillance Registry, (the sole source of data acquisition for neural tube defects and many other types of birth defects in Kentucky) and the Kentucky Folic Acid Supplementation Program. In collaboration, these programs will provide area development district information to local health departments so that areas with the highest rates can increase their prevention efforts.

State Performance Measure 2: *Percent of counties with comprehensive child safety education and injury prevention programs in place.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	85	90.0	90.0	85	90
Annual Indicator	89.2	92.5	80.8	80.8	70.8
Numerator	107	111	97	97	85
Denominator	120	120	120	120	120
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	95	98	98	98	98

Notes - 2002

Inclusion in this measure occurs when a county has identified the primary sources of childhood injury unique to that area (i.e. drowning, MVA, etc) and has a comprehensive child safety education and injury prevention program in place to address these specific causes of injury.

Notes - 2003

"Comprehensive" means that each county must implement various safety programs based on the unique needs of the community. These may include, but are not limited to, Safe Communities, Safe Sitters, Risk Watch, Buckle Up and CPR.

a. Last Year's Accomplishments

The word "comprehensive" safety education has been re-defined as a safety plan that concentrates solely on unintentional injury. The provider conducts multifaceted injury prevention activities emphasizing problems affecting high-risk populations. Curricula for the particular audience and the cause of injury are the main focus. Curricula may include Safe Kids, Safe Communities, Safe Sitters, Risk Watch, Buckle Up prevention programs, and life support education such as American Heart Association cardiopulmonary resuscitation (CPR)

standards.

All 120 local health departments in Kentucky have some form of child safety education and injury prevention program. In 2001, 92.5% of Kentucky's 120 counties had injury prevention programs. In 2002 and 2003, this declined slightly to 80.8%. With an emphasis on population-based services at the local health department level, FY 2004 reflected that 71% of the county health departments are offering child safety education and injury prevention programs on a comprehensive basis. This decline is due in part to the change in the definition of "comprehensive". Traditionally these services were provided within the local health department as patients received preventive clinical health services. As the demand for clinical health services decreases new opportunities are available for population based injury prevention efforts that reach the entire community. Within the past year, significant strides have been made to increase the variety of community based injury prevention programs offered by Kentucky's local health departments.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Safe Kids Coalitions locally and statewide with programming appropriate for each community.		X		X
2. Child Fatality Review to continually monitor deaths due to injuries and other causes.		X		X
3. Collaboration with KIPRC - University of Kentucky Injury Prevention Research Center.		X		X
4. Collabortion with Coordinated School Health for educational materials that promote physical activities in a safe manner.		X	X	X
5. Healthy Start in Childcare program to work with preschools, assuring safety in the preschool setting		X	X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The child fatality review (CFR) and injury prevention program emphasizes services for Kentucky children under age 18. Its mission is to reduce child health and life threatening conditions and injuries, most of which are preventable. All of Kentucky's 120 county Local Health Departments participate in public outreach child injury and death prevention education and behavior change activities each year.

Local health departments offer grief counseling to any family whose child under age 18 has died. Grief counselors are trained each year to provide support and to offer families the opportunity to evaluate the possibility of personal, medical, financial and other needs to be met for the family during the time of bereavement.

The department facilitates development of local child fatality review teams, a vital system component important to reducing child deaths. Seventy-one percent of the Kentucky's 120 counties voluntarily have organized local child fatality review teams, with development of new

or reorganizing of formally existing teams occurring throughout each year.

The department publishes a child fatality review annual report to identify trends regarding child health and life threats, populations and age groups of highest risk in the various child death categories.

For the 2004-2005 fiscal year grant funding was obtained to purchase educational materials for use by Kentucky local health departments in school health education programs. Each informational packet encourages childhood exercise in the areas of walking, bicycling, skating, skateboarding, swimming, emphasizing the safety aspects while the child is participating in the activities. This is an effort of the program to promote healthier children by reducing childhood obesity in a safe manner.

An educational phamplet was developed with staff from maternal and child health, WIC and HANDS to provide parents with safe sleeping tips for babies. This was a joint effort to reduce infant deaths due to suffocation.

c. Plan for the Coming Year

Additionally, MCH provides support to the Kentucky Department for Mental Health and Mental Retardation to increase efforts in reducing youth suicides. MCH staff are members of the Suicide Prevention Workgroup and MHMR staff are members of the State Child Fatality Review Team. The groups will sponsor Suicide Prevention Week, September 4-10, 2005 as part of a media campaign. A conference entitled "Suicide Prevention: It's Everybody's Business" will be held September 6-7, 2005 and "Palette of Grief" a post-conference experience will be held September 8-9, 2005. Both events will be held in Louisville. For more information you may contact their website at: http://mhmr.ky.gov/mhsas/suicidepreventiongroup.asp

The Suicide Prevention Workgroup has developed a Suicide Prevention Plan and a copy may be obtained by contacting the website listed above.

During 2004 and continuing through 2006, the CFR state team initiated studies of child death prevention systems related to data, education, local child death review, legislation and financial support. These reviews include transportation associated injuries, infant suffocations, homicides, suicides and drug abuse. The first child death cause reviews initiated include transportation related injuries, infant suffocations, homicides, suicides and drug abuse child death causes.

The CFR and Injury Prevention Program administrator and CFR state team membrs will continue outreach activities to local health department staff through increased communication and on-site visits, Technical assistance, coordination of family grief counseling training and other education opportunities will also be provided.

State Performance Measure 4: *Rate of substantiated incidence of child abuse, neglect, or dependency.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2000	2001	2002	2003	2004

Data					
Annual Performance Objective	26.0	20	19	17	16
Annual Indicator	21.9	19.9	18.3	17.7	17.7
Numerator	21742	19767	17007	16468	16468
Denominator	994818	994818	931588	931588	931588
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	15	15	14	14	14

Notes - 2003

Denominator Data is Population Estimates from 2002 - Kentucky State Data Center

Neglect/Abuse Data from Mary Glasscock (CHFS OIT DAB)

a. Last Year's Accomplishments

The rate of substantiated incidence of child abuse, neglect or dependency has dropped dramatically from past years; in 1998 the rate per 1000 children was 28.7, in 1999 was 22.5, in 2000 was 21.9 and 2001 was 19.9. Data for 2002 (18.3) and 2003 (17.7) continued the trend.

The home visitation efforts have been demonstrated in other states to have an impact on the incidence of child abuse and neglect. Partnerships to increase home visitation services and information on the importance of early brain development should assist in meeting this measure. The child fatality review system has strong support at both the community and state level for expertise in this area. All parenting components in local health department services stress the expectations for normal child growth and development and resources available to assist families.

Initial results shown by HANDS show lower cases of physical abuse and neglect of babies. Non-HANDS families exhibit 58% more child abuse and 62% more neglect than families participating in HANDS.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Continuation of HANDS Voluntary Home Visitation Program.	**X**	**X**	**X**	**X**
2. Child Fatality Review Data System for on-going surveillance of child deaths				**X**
3. Healthy Start in Childcare program to work with preschools, assuring safety in the preschool setting			**X**	**X**
4. On-going monitoring of HANDS data and HANDS evaluation process				**X**
5. Full implementation of the Mental Health in Child Care Initiative.				**X**
6.				

7.				
8.				
9.				
10.				

b. Current Activities

Current activities mirror those described in the previous section. HANDS is now operational in all 120 Kentucky counties and is working collaboratively with the Department for Community Based Services and local health departments. A 2004 study of child abuse and neglect found that participating teens in HANDS had no incidents of substantiated physical, sexual or emotional abuse.

Staff from the Deaprtment for Community Based Services is a member of the Injury Prevention program advisory workgroup and brings her knowledge and experience to the group.

Child Abuse and Neglect training is provided to local health health department nurses that will be completing comprehensive preventive child health exams as part of EPSDT and the Well Child programs.

c. Plan for the Coming Year

Future activities will mirror those described in the previous section. HANDS is now operational in all 120 Kentucky counties and is working collaboratively with the Department for Community Based Services and local health departments.

The success of the program is expected to continue and to be more evident as data becomes available.

State Performance Measure 5: *Number of families receiving support services/parenting assistance through the HANDS (Health Access Nurturing Development Services) home visiting support program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	2500	3778	7378	8500	8500
Annual Indicator	2866	3873	7324	9528	10453
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective	10500	10500	10500	10500	10800

Notes - 2002

Accurate data for this measure has proven difficult to obtain.

In the initial roll-out year of HANDS, 15 counties were selected to participate in a pilot program. These counties tended to be areas of highest need; with small populations scattered within a rural setting. In many cases, half of the population was supported through government assistance. Several of these counties were located in Eastern Kentucky; the foothills of the Appalachian Region.

Because of this, the percentage of participation in HANDS was extremely high in the first year.

In subsequent years, as additional counties participate with higher populations and proportionally less need, it is expected that the state-wide percentage of participation will decline. But the resulting portion of the population that does participate will represent the true need for the state rather than a skewed picture focusing on a few counties.

Notes - 2003

ECS Total in only.

Notes - 2004

Numinator and Denominator data cannot be obtained, only total number of families served.

a. Last Year's Accomplishments

The HANDS program is coordinated by the Division of Adult and Child Health Improvement under the Department for Public Health. The purpose of this program is to provide home visitation to overburdened first-time families to assist them in meeting the challenges of parenting beginning prenatally and continuing during the child's first two years of life. Anticipated results are to achieve positive pregnancy outcomes, to improve the health and developmental outcomes for children, to have children in healthy and safe homes and to reduce the likelihood of child abuse and neglect over the long term. HANDS began in eleven pilot counties in December of 1998 and in the spring of 1999, four additional counties were added. In FY 01, an additional thirty-two counties were added bringing the total participating counties to forty-seven. FY02 brought about 54 additional new counties totaling 101 participating counties and in FY03, statewide coverage of all 120 Kentucky counties was achieved. A brief description of the HANDS enrollment process follows.

Step 1: HANDS Referral Record Screen: completed on mothers/fathers of all first-time families. The screen can be completed at different community sites such as a local health department, hospitals, physician offices, etc. The screen indicates stress factors such as unemployment, inadequate income, unstable housing, limited parental education, isolation, history of substance abuse, poor prenatal care and maternal depression. All first time mothers/fathers with a positive screen will be offered a family assessment referred to as the Parent Survey.

Step 2: Parent Survey: assesses the family by looking at both the mother and the father and focusing on their family history. A registered nurse, social worker, or other professional who has additional training on assessments will complete the Parent Survey. All first-time mothers/fathers with a positive assessment will be offered the home visitation services of HANDS. For an assessment to be positive a parent/partner must score 25 or higher.

Step 3: Entering the HANDS Program: first time families accepting the HANDS program will have a trained Home Visitor providing home visiting services based on family need until the child is age two. During the prenatal period the visits will focus medically on the need for

prenatal care, fetal development, avoiding alcohol, smoking, and drugs and on the social model of reducing the stressors in the home before the infant is born. After delivery the focus for the infant will be health care, medical home, child growth and development, immunizations, screening for possible developmental delays anticipatory guidance. In addition, the social model of encouraging parents to become responsible and self-sufficient for their family and promoting parent child interaction will be emphasized through a parenting curriculum.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuation of HANDS Voluntary Home Visiting Program for all families in Kentucky.	X	X	X	X
2. Development of Quality Assurance Efforts to include site self-assessment, drop-out/retention rate monitoring, parent satisfaction survey and analsysis of outcome data.				X
3. Enhancement of HANDS database and reporting capabilities				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Our annual performance target will be to reach 50 percent of all first-time Kentucky families. All teens with a negative screen or assessment will be offered a once a month home visitation program commonly referred to as "low-intensive track of HANDS" and formerly known as Resource Persons.

Evaluation Services for HANDS is being provided by Resources for Education, Adaptation, Change, and Health, Incorporated (R.E.A.C.H. of Louisville, Inc.) Robert J. Illback, Executive Director.

In 2001, 3,873 families participated in the HANDS program. Single, separated or divorced parents headed sixty-five percent of these families. Sixty-four percent of families had inadequate or no income source while thirty-two percent were unemployed. Forty-two percent had an education less than 12 years and twenty percent had unstable housing. In 2002, total individuals served increased again to 6,643 families. Sixty-nine percent of these families were headed by single, separated or divorced parents, 73.5% had inadequate or no income source (a substantial increase over 2001) and 33% were unemployed.

According to the KIDS NOW Early Childhood Initiative Summary dated April 2005, in FY 2005, 10,184 families participated in HANDS. All 120 counties were participating and 4,886 assessments were conducted. 42,555 professional home visits and 68,566 paraprofessional home visits were conducted.

Birth indicators based on 2000-2003 data showed HANDS participants to have fewer premature infants, fewer low and very low birth weight infants, and fewer birth defects when

compared to other first time parents who did not participate in the weekly home visitation program. Likewise, Infant Mortality rates per thousand for HANDS (1.6) compared to the statewide Kentucky (6.4) rate were significantly lower in 2002. A 2004 study of child abuse and neglect found that participating teens in HANDS had no incidents of substantiated physical, sexual or emotional abuse.

Over the past year emphasis has been placed on Quality Assurance and Data Analysis activities for the program. Statewide Quality Assurance efforts have been implemented through the following:

· Sites utilization of the TA Site Visit Summary Checklist as a self-assessment tool

· Summary of site checklists results to evaluate program trends and opportunities for growth

· Summary of TA Satisfaction Surveys

· Analysis of State Program Evaluation (yearly)

Data Analysis efforts have included:

Development and initial implementation of a web based data system which has been designed to provide "real time" data, be more user-friendly, minimize occurrences of data entry errors, and collection additional information not available in the previous system.
Analysis of HANDS software reports (quarterly)
Referral sources, home visits (cancelled/ attempts), high refusal rate for parent survey, high refusal rate for parent survey, high refusal rate for home visitation, employee turnover/retention.

c. Plan for the Coming Year

Continue with implementation of phase II activities identified as essential to the on-going utilization of the recently developed web based data system. (follow up training, modifications, links, etc.)

Begin use of the HELP (Hawaii Early Learning Profile) developmental assessment. The checklist format will be utilized in combination with the existing Growing Great Kids curriculum to monitor each child's development and provide families with additional resources/activities to facilitate their child's development.

Research maternal depression screening and design plan for future introduction.

Utilize revised Growing Great Kids curriculum and expand the curriculum by supplementing with information from various Kentucky Public Health programs.

Offer the first HANDS Fall Retreat to all sites for opportunities to network and obtain required training.

Analysis of site parent satisfaction survey (yearly)

Training needs have been tracked through review of site team training logs. In addition, the Training Coordinator has been working with the TRAIN program so that HANDS staff can register for required training through this web system. This system provides each staff with an on-going account of their professional development.

State Performance Measure 6: *Percent of children with inappropriate weight for height.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	11	10	13	21.9	22.5
Annual Indicator	19.6	19.9	21.4	25.0	27.0
Numerator				22500	24840
Denominator				90000	92000
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	25	25	25	24	24

Notes - 2003

Kentucky Pediatric Nutrition Surveillance Data for each year:

1999 13.3 Overweight and 6.4 Underweight
2000 13.4 Overweight and 6.2 Underweight
2001 14.1 Overweight and 5.8 Underweight
2002 16.8 Overweight and 4.6 Underweight

Source: Nutrition Services Branch (Emma Walters, primary contact).

Note: Projected totals for future years are based on realistic assumptions regarding the health problem that Kentucky faces with obesity in our youth. We hope that our estimates are proved wrong and that numbers decline more quickly for future years. The many partners working toward this goal remain optimistic but chose to project cautiously into the future.

Notes - 2004

Numerator and Denominator data are not available only the total percent is available.

a. Last Year's Accomplishments

For FY 2004-2005, the $1.5 million from the MCH Block Grant was allocated for community and clinical nutrition services. Nutritionists, nurses, dietitians and health educators can provide these community services. The clinical services to provide Medical Nutrition Therapy (MNT) must only be provided by Registered Dietitians or Certified Nutritionists from the health department or referrals to local dietitians.

Community efforts for 2004-2005 include continued focus on increasing the incidence and duration of breastfeeding, Choose 1% or Less, 5 A Day and Weight Loss programs. During May and June 2004, training is being provided to 40 local health agencies to implement a 5 A Day Program centered around the 5 A Day Challenge. The activities that will be generated from this training will occur in FY 2005.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Growing Healthy Kids II Conference		X		X
2. Unified program efforts throughout Kentucky in the area of nutrition and physical activity		X	X	X
3. Targeting of a portion of the Title V Block Grant funding and all of the Primary Health Block Grant		X	X	X
4. Science-based interventions at the local level, monitored by the nutrition staff		X		X
5. Efforts to increase the prevalence and duration of breastfeeding.		X	X	X
6. Training for local health department nutrition staff to include 5-A-Day program and worksite wellness.		X	X	X
7. Coordination with other CDC grants, to include Cardiovascular, Obestiy Prevention and School-Based Coordination.		X		X
8.				
9.				
10.				

b. Current Activities

Inappropriate weight for height continues as a problem in Kentucky. During 2003, short stature continues to be above the expected rate of 5% for low-income children under the age of 5 and is at a rate of 7.4%. At risk for overweight and obesity in this population is three times the expected rate and is respectively, 17.8% and 17.2% in 2003. In 2003, high school students showed a rate of 15.3% at risk for overweight and 14.6% are overweight reported in the Youth Risk Behavioral Surveillance System. In the 2002 Youth Tobacco Survey, 17.5% of middle school students are at risk for overweight and 16.8% are overweight. In 2002, 62.7% of adults were reported to be overweight and obese.

The following activities were conducted to assist in addressing the problem of overweight and obesity:
•Maintained the network of 140 public health nutritionists to provide Medical Nutrition Therapy in 110 of 120 counties. Approximately 10,000 visits are expected to be provided in 2005 to address nutrition problems with obesity being the leading diagnosis of MNT visits.
•Provided funding for community nutrition activities that include programs on 5 A Day, Choose 1% or Less, Weight Control, etc. School activities are also provided through this funding and these address nutrition and physical activity. Program plans from the local agencies include evidenced based or best practice programs in the area of nutrition and physical activity.
•Conducted training on the importance of breastfeeding in the prevention of chronic diseases including obesity, diabetes and heart disease.
•Conducted training on 5 A Day Challenge for the last 14 agencies to provide technical assistance in conducting a community wide media campaign to increase fruits and vegetable consumption.
•Co-sponsored the Growing Healthy Kids III (2004) and IV (2005) providing education and materials to teachers, health educators, parents and health professionals addressing nutrition and physical activity curricula and materials.
•Developed and implemented Breastfeeding Peer Counseling Program in four pilot sites.

The following activities were conducted to address nutrition issues for childbearing age and

pregnant women:
•Revised and placed on the DPH website the folic acid PowerPoint materials for KY health professionals.
•Updated the specifications for prenatal vitamins for use in health department clinics.
During 2005 the following activities were provided to address leading nutrition problems affecting the MCH population:
•Provided continuing education programs across the state addressing nutrition, medications and physical activity for people with diabetes.
•Conducted continuing education programs across the state addressing renal disease.
•Revised nutrition education materials to reflect the changes in the Dietary Guidelines 2005 and My Pyramid.
•Offered continuing education programs addressing the links between My Pyramid, Dietary Guidelines 2005 and Food Label and how to provide effective education messages.

c. Plan for the Coming Year

With the leading nutrition problems continuing to be obesity, heart disease and diabetes, efforts in nutrition will focus on the following activities for the MCH population:

Continue funding for Medical Nutrition Therapy services at the local health departments.

Maintain funding for the community nutrition programs addressing 5 A Day, Choose 1% or Less and Weight Control.

Expand and maintain the Breastfeeding Peer Counseling Program.

Provide revised nutrition materials addressing the following topics: Food safety, Mercury, BMI, DASH diet, Healthy Dining Out, Jaundice and Breastfeeding.

Worksite wellness is another important issue that will receive attention during the next fiscal year at the State and Local level. Worksite packets are being developed to focus on the importance of nutrition, physical activity and breastfeeding friendly facilities. In an effort to coordinate nutrition services with the CDC Obesity Grant, we will continue to focus the State and local efforts on statewide campaigns in order to create positive change.

Discussion of Kentucky's CDC Grant - State Nutrition & Physical Activity Programs to Prevent Obesity and Other Chronic Diseases is included within Section IV, E. - Other Program Activities.

State Performance Measure 7: *Percent of counties who review child deaths with a local multidisciplinary investigation team.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	40.0	50	55	75	85
Annual Indicator	49.2	52.5	52.5	45.0	45.0

Numerator	59	63	63	54	54
Denominator	120	120	120	120	120
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	95	95	96	96

Notes - 2002

Activities are in place to assure that each county has such a team in place. Please see narrative for further details.

Notes - 2003

County teams, in order to be included within this performance measure, must meet face-to-face to review child deaths; at least twice per year.

a. Last Year's Accomplishments

General Information: Child Fatality Review and Injury Prevention

In 1996, House Bill 94 was passed by the Kentucky General Assembly to provide a state child fatality review and injury prevention system, and a multidisciplinary approach to the review of local coroner jurisdiction child fatalities. This review includes all unexpected or unexplained fatalities such as those due to obvious injuries, unexpected fatalities with questionable circumstances, and/or non-apparent injuries. The law mandates that coroners must contact the local Department of Community Based Services (DCBS), local law enforcement, and the local health department with information relevant to each child death. Coroners must submit reports to the Kentucky Department for Public Health (DPH). DPH utilizes information from the local multidisciplinary reviews in its annually published child fatality review report to the Kentucky legislature.

Programs that can affect this measure for primary and preventive services for women and infants include the Family Grief Counseling Program, Injury Prevention that includes prevention program focuses such as the Child Safety Seat Program, prevention of Child Abuse and Neglect, Healthy Lifestyle Education, and Infant Mortality Review. Other preventive and primary services for children include Child Fatality Review and HANDS. Staff is working collaboratively with partners to increase training opportunities for child fatality review and grief counseling. Seed monies to local health departments to take the lead on developing child fatality review teams assisted in this improvement.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Expansion of child fatality review teams in each county.		**X**		**X**
2. Participation on the National Child Fatality Review Center to develop national reporting tool		**X**		**X**
3. Annual publication of the child fatality review report				**X**
4. On-going data analysis of child deaths and causes.				**X**

5. Improved Child Fatality Review database with reporting capabilities				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The percent of counties who participate in the review of child deaths with local multidisciplinary investigation teams continues to increase, from 47.3% in 1997 to 52.5% in 2002. Following an evaluation of the current process, it was determined that of the 2002 coroner investigated child deaths, 45% underwent a multidisciplinary team review.

Funding to local health departments to assist local child fatality review teams was provided in the FY03 and FY04 budget years. A goal was established so that this funding and help from local health department staff, the state program administrator and Child Fatality Review (CFR) state team members, would facilitate development of 25 new teams and support continuation of the new and pre-existing teams. CFR team activity was monitored through reports received from local health departments.

The results surpassed expectations regarding development of 25 new teams, in that 28 new teams were organized. It is estimated that Kentucky is approaching about 70% of its counties having local CFR team activity. Ongoing financial incentives and state and local personnel outreach activities are vital to local CFR team survival and multidisciplinary review of child deaths.

c. Plan for the Coming Year

The Department for Public Health will continue to provide flexible funding to local health departments to be used for Child Fatality Review and Injury Prevention projects. At the discretion of the health department some of the funds may be allocated to assist local child fatality review. Other agencies represented on the local CFR team will be encouraged to provide financial and other supportive services as well.

Required participants in a local child fatality review team include the county coroner, law enforcement, local health department and community-based services representatives. Additional participants may include EMS, other medical personnel such as a pediatrician, a county legal representative, a child abuse/domestic violence specialist and a citizen advocate. Meetings should be minimally twice a year with additional meetings as needed.

Kentucky is monitoring the work by the National Child Fatality Review Center (Okemos, MI) to develop a national report tool and data system for Child Death Review Programs. The committee's responsibility will include a review of case and annual reports currently in use by local and state programs. The assigned task will be to review what is currently in use to create the best hybrid possible, one that can then be easily adapted by any program. From June 2003 until December 2004, the committee's task was to develop a standardized case report tool and set of definitions/instructions. As this is occurring, software programmers will be developing the web-based data system for all programs nationally. In 2004 through a period in 2005, pilot testing of the developed report tool has been undertaken by approximately 17 states. This tool will be reviewed for use by Kentucky as it becomes avaiable.

State Performance Measure 12: *Percentage of Medicaid enrolled members ages 0 through 21 who were continuously enrolled during the reporting year and who had at least one dental visit during the reporting year.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	18	20	40	40	42
Annual Indicator	21.8	25.2	26.6	28.2	29.9
Numerator	89314	106596	112275	118642	123320
Denominator	408945	423180	422684	421364	412916
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	30	33	35	37	40

a. Last Year's Accomplishments

This measure continues to improve although more slowly than the State Oral Health Program office would like to see. With permission from our regional contact at the Maternal and Child Health Bureau, the Department for Medicaid Services re-ran the data for the past five years to develop a consistant method of analysis for data contained in this measure. Some questions remain about "continuously enrolled" and how this is defined within the Medicaid System.

What steps has Kentucky been taking to improve access for care for children with Medicaid and KCHIP?

1) The Department for Medicaid Services has developed resources to communicate with dentists about the importance of providing early care to children. The numbers of children seen by providers have increased by nearly 30% because of this effort.

2) Dentists who currently treat children enrolled in Medicaid have increased the number of clients that are seen.

3) The Kentucky Dental Association also has been very proactive in promoting this program to their membership.

4) Strong partnerships have been developed between the state Oral Health Program, local health departments and dentists, to promote dental care for this population.

5) The HANDS Home Visitation Program, now operational in all 120 counties and serving over 7,000 Kentucky families, has emphasized the importance of early attention to oral health.

6) Finally, the addition of a health education staff member at the state level has increased communication and knowledge between all partners in the area of children oral health; as well as the importance of oral health in the maternal population.

All of these reasons have contributed to the success that now benefits Kentucky's children in the area of oral health.

Kentucky's Oral Health Strategic Planning process, discussed earlier within the narrative, also included Medicaid partners. The primary reasons for lack of access includes looming shortages of dentists for all clients as well as a maldistribution of providers in many rural areas, the continued shortage of providers willing to take Medicaid clients and low reimbursement rates for these providers. Reasons residing with Medicaid families include a lack of knowledge about oral health as well as a culture that does not place great importance on healthy teeth and gums. Transportion and distance to providers is also a substantial barrier.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued support of regional system for dental care, through cooperative efforts by the Director of Oral Health (DPH) and partners throughout the state, increasing access in areas of provider shortages.			X	X
2. On-going strategic planning for children's oral health in Kentucky. Completed report by Fall 2004.				X
3. Continued work with Kentucky Dental Association and associated organizations, to raise Medicaid reimbursement rates for dental services and simplify reimbursement processes.				X
4. Ongoing partnership with Kentucky Department for Medicaid Services, Cabinet for Child and Family Services, to coordinate oral health efforts.				X
5. Continued education at the local level, encouraging local dental providers to increase the proportion of Medicaid enrollees seen in their practice.				X
6. Discussion of provider shortages and partnerships with dental associations to consider mid-level provider opportunities in dental shortage areas.				
7.				
8.				
9.				
10.				

b. Current Activities

Plans for the future for this program include continued partnership opportunities between the Department for Public Health, the Department for Medicaid Services at the state and community levels. While the primary issue for this measure involves increased numbers of dental homes for children enrolled in Medicaid, much is being done to serve these children until a regular dental home can be established.

The Kids Smile Program will continue to provide fluoride varnish applications to children by local health department nurses and sealant projects are currently underway in many local

health departments. The Oral Health Program collaborates with the HANDS Home Visitation Program to get out important oral health messages to families served by HANDS. Through programs such as HANDS, the Oral Health Office not only hopes to provide direct services for children but also to educate families about the importance of oral health care; creating an expectation of these services as a part of the culture of the Medicaid population.

Through MCHB's Oral Health Collaborative Systems Grant, work will continue on the Oral Health Surveillance System to measure the needs of Kentucky children and on a new Workforce Study to be conducted by the University of Louisville. This will provide detailed information on providers needed throughout the state; including those taking Medicaid clients and those seeing only private patients.

As a part of our Oral Health Strategic Planning Process, Kentucky is reviewing its needs in the area of workforce as well as funding and advocacy issues.

The need for increased partnerships and cross-training opportunities have been discussed (such as the fluoride varnish program now in local health departments and the inclusion of oral health training for residents through the Pikeville School of Osteopathic Medicine) as well as discussions about the role of a mid-level practitioner for service provision in dental health professional shortage areas.

Committee members participating in the "Funding" and "Advocacy" Workgroups noted the need to increase Kentucky Medicaid fees from the present levels to the 75th percentile of usual and customary fees (as reported by the American Dental Association for Kentucky's region) by January 1, 2010. Also noted is the need to work with Medicaid patients to teach them how to be better patients and to decrease the complexity of Medicaid paperwork for providers. Finally, committee members intend to carve-out a dental Medicaid Program and establish a single-payer system for dental services by December 2006.

c. Plan for the Coming Year

A strong partnership between the Kentucky Department for Public Health and the Department for Medicaid Services will continue during FY06.

All programs mentioned above will continue with special emphasis on needs identified within the Oral Health Strategic Planning Process that relates to Medicaid. Workgroup meetings will continue with funding provided by the Oral Health Collaborative Systems Grants as providers and community representatives continue to address problems identified within the Medicaid System related to oral health.

Dr. James Cecil and members of the Kentucky Dental Assocation are currently working on many of these initiatives and specifically note changes necessary to the Medicaid Program necessary for improved oral health for Kentucky's Medicaid population.

Goal: Carve out the Medicaid dental benefit from Medicaid with reallocation and cost-containment to improve access.

Discussion: In order for the dental Medicaid program to be enhanced as a benefit, better managed, and sustained, a dental benefit manager should be procured to manage the program to eliminate waste, control fraud, assure appropriate treatment to eligible beneficiaries, and enhance the oral and systemic health of the Medicaid and KCHIP population.

The following are recommended for implementation:

- Restructure the benefits (e.g., orthodontic benefit preauthorization

process, add debridement code, add primary tooth root canal
therapy, and other modernizations)
- Improve EPSDT utilization by more providers -- education.
- Provide mechanism to reimburse local Health Departments for services.
provided by volunteer dentists and hygienists in sealant and other prevention program.
- Reduction in overuse of ERs for dental infections and pain by Medicaid beneficiaries to save funds
- Increase access to care from about 25% to 50% of eligibles through education of Medicaid beneficiaries and enlist greater participation by Medicaid providers by modernizing the dental benefit to align with the needs of the population.
- Improve accountability on the part of patients and providers through education and training.

State Performance Measure 13: *The proportion of young people who have smoked cigarettes within the past 30 days.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	43	33	33	33	32
Annual Indicator	37.0	33	34	32.7	0
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	32	31	30	30	30

Notes - 2002

2002 Data is not available using the Youth Behavioral Risk Factor Surveillance System.

Notes - 2003

Kentucky YBRS is only done every other year. We hope to find other vehicles in which we can answer this measure annually.

Notes - 2004

The YRBS was not conducted in 2004 and data is not available.

a. Last Year's Accomplishments

The Youth Risk Behavior Survey (YRBS) and the Youth Tobacco Survey (KYTS) are Kentucky's data sources for this performance measure. The YRBS and KYTS were conducted concurrently in 2004. Results from the surveys are not yet available.

Tobacco Prevention and Cessation Program is funded by the Tobacco Master Settlement Agreement (MSA) and a grant from the Centers for Disease Control and Prevention (CDC).

Local health department staff teaches prevention education in schools, provides smoking cessation programs, conducts community assessments, offers technical assistance to schools and businesses, and develops coalitions to promote and provide community interventions related to tobacco use.

The Healthy Kentuckians 2010 Goal: Increase to 100 % the number of schools that ban tobacco use on all school property. According to the 2003 School Policy Survey, 96.6% of middle and high schools ban smoking on school grounds. Although most schools banned smoking on school grounds, only 41.7% banned smoking for employees on school grounds.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Take the Smoke-Free Home Pledge for parents		X	X	
2. Media Campaign with the Smoke-Free Home Pledge		X	X	
3. Continued programming activity at local health departments.		X		X
4. Spit-tobacco cessation project cooridnated by the Oral Health for local health department clients		X	X	
5. Smoking cessation coordinators in each local health dept.		X		X
6. Reduction of smoking by women who are pregnant through a partnershipwith Medicaid, a mass media campaign and technical assistance to private and public providers.		X	X	X
7. Clean indoor air policies in Public Places and in workplaces, to reduce exposure to secondhand smoke and adult prevalence.		X		X
8.				
9.				
10.				

b. Current Activities

Currently, 100% of local health departments coordinate teen smoking prevention activities, including teen smoking cessation activities and are working to assist adults (particularly pregnant women) with smoking cessation efforts. Some of the programs being used through the public health system in Kentucky are LifeSkills, The Cooper/Clayton Method to Stop Smoking, Make Yours a Fresh Start Family, TEG/TAP, NOT, and TATU.

Fifteen local health departments promoted Tobacco-Free Sports programs this spring. The Kentucky Department of Education Coordinated School Health Grant purchased water bottles and banners for distribution to the participating teams. Coaches and players sign tobacco-free pledges at the beginning of the season. Health educators offer information about tobacco use, nutrition, and physical activity during the season to coaches, players, and parents.

In collaboration with the Tobacco Environmental Strategies Prevention Enhancement Site (funded by the Substance Abuse Program), six youth conferences were held in the spring to focus on building an advocacy movement in the state. Over 700 youth attended the conferences where they elected state representatives and learned how they can become peer educators and advocates to reduce tobacco use in their schools and communities. A "brand" will be selected by the state teen advisory board and a web site will be created for youth to share ideas.

To further promote the youth movement, the Tobacco Prevention and Cessation Program, truth television ads are running on statewide. Legacy matched state funds for a total of $300,000. The ads are aimed at youth to discourage smoking and encourage advocacy.

A state quitline, funded by a CDC grant, became operative July 1, 2005. Research shows that calling a quitline can double, even triple, the chances of successfully quitting. Trained counselors can tailor services to the individual smoker. An informational Fact Sheet on Kentucky's Tobacco Quit Line is attached.

c. Plan for the Coming Year

Grants will again be available for youth conferences in the fall. The conferences are a collaborative effort between the youth advisory board, health departments, Regional Prevention Centers, and other community partners including schools.

Nine community forums across Kentucky in August and September. Forums will gather input from Kentuckians on "What is your community doing now to address tobacco use?" and "What would you like to see your community doing to address tobacco use?" The format will be similar to the obesity forums from 2004 and will be held in cities that have or are considering a smoking ban. This another initiative of Gov. Fletcher's Get Healthy! Kentucky Campaign.

The Department for Public Health will provide smoking cessation counseling during family palnning visits. Packets will be provided on smoking and pregnancy with each positive pregnancy result.

Make Yours a Fresh Start Family training is being provided to local health department nurses, health educators and dieticians.

DPH will promote Tobacco-Free Sports through materials and funding as available.

E. OTHER PROGRAM ACTIVITIES

Division of Adult and Child Health Improvement

-State Nutrition & Physical Activity Programs to Prevent Obesity and Other Chronic Diseases

With the ever increasing problem of obesity in the area of maternal and child health, the Division was pleased to receive this grant from the Centers for Disease Control and Prevention. This planning grant provides funding for state and community partners to build this collaborative program with the expectation of implementation funding in the near future.

During the first year, 3 full time positions were hired: a program director, a physical activity coordinator and a nutrition coordinator. This team completed a comprehensive state plan to address the 6 areas of the grant: increase physical activity, increase fruit and vegetable consumption, increase breastfeeding, increase parental involvement, decrease computer and television screen time, and other dietary changes.

Copies of the state plan, Kentucky Obesity Epidemic 2004 may be obtained on the website www.fitky.org. The report categorizes obesity as an epidemic and revealed that medical costs for treatment of obesity-related health conditions were more than $1.1 billion last year.

Following the report, nine regional forums were held throughout the month of August 2004 as part of Governor Ernie Fletcher's Get Healthy Kentucky! initiative to gauge community support to fight obesity

on the local level and solicit input on how best to address barriers to good health. Approximately 1,300 people attended and provided input.

The workshop-style forums consisted of small-group sessions in which participants listed all the things that currently are being done in their communities and what they'd like to see done to encourage breastfeeding, consumption of fruits and vegetables, physical activity, parental involvement and other dietary changes and to decrease television and computer time.

Among the recommendations cited most frequently by forum participants were: making daily physical education and physical activity mandatory for all K-12 students; offering healthy food choices in school vending machines; and providing more affordable, accessible, family-friendly opportunities for physical activity in local communities.
Holsinger said information gleaned from the regional forums will be used to craft an action plan to guide the state's campaign to reduce the rate of obesity and overweight and encourage Kentuckians to adopt healthy eating and exercise habits.

Forum participants raised a variety of issues, many of which echoed similar themes, while others reflected the state's environmental, cultural, social, economic and community diversity. For instance, where unsafe neighborhoods are a barrier to physical activity in one region, the lack of sidewalks and bike trails is a barrier in another.

Obesity is the first focus issue to be addressed as part of Governor Fletcher's Get Healthy Kentucky! initiative. Others health issues to be addressed over the coming months and years include use and abuse of tobacco, alcohol and drugs, immunizations, dental care, regular, ongoing primary care and healthy babies.

These areas of improvement will be accomplished through partnerships between many groups including schools, business and industry, public health and health care, families and communities and those focusing on the environment. A diverse group of individuals discussed current activities (in their communities and statewide), their ideas for the future and how the Department for Public Health can support their local work. Participants included schools, business, healthcare, political leaders, non-profits and consumers.

-State Strategic Prevention Framework State Incentive Grant

In October 2004, the Department for Public Health was awarded a 5 to 7 year, $11.5 million Strategic Prevention Framework State Incentive Grant (SPF-SIG) from the US Department of Health and Human Services, Substance Abuse & Mental Health Services Administration (SAMHSA). The Strategic Prevention Framework is a process designed to increase the effectiveness of substance abuse prevention on the state and local level through collaborative interagency planning. To this end, Kentucky's initiative will bring together 6 Key Partner Agencies (the Department for Public Health, the Department of Education, the Department for Juvenile Justice, the Department for Mental Health and Mental Retardation Services, the Department of Family Resources and Youth Services and the Governor's Highway Traffic Safety Initiative) to draft a statewide strategic plan and to work through their local agencies in targeted communities to implement research based prevention programs and strategies. Each of the Key Partner Agencies will create and implement home teams to help with implementation. The Framework is a five-step process to expand, extend, and more fully integrate the state substance abuse prevention infrastructure.

-Rape Prevention and EducationI grant

In May, 2005, Maternal and Child Health staff, in collaboration with the Kentucky Association of Sexual Assault Prevention and the Department of Human Support Services, Division of Child Abuse and Domestic Violence Services, submitted a $100,000 grant request for a three year project period to fund "Building Comprehensive Prevention Program Planning and Evaluation Capacity for Rape Prevention and Education Funded Programs" to the Centers for Disease Control and Prevention

(CDC).

The purpose of the grant is to build comprehensive prevention program planning and evaluation capacity among selected Rape Prevention and Education (RPE) funded sexual violence prevention programs and to assess short-term and intermediate capacity building outcomes for each program. Prevention program planning and evaluation will be focused on the national Rape Prevention and Education Program logic model as well as comprehensive primary prevention strategies.

Notice of grant awards should be announced in August, 2005.

F. TECHNICAL ASSISTANCE

The Commission for Children with Special Health Care Needs and the Division of Adult and Child Health Improvement will discuss TA needs individually within this section.

Commission for Children with Special Health Care Needs:

Request will be made during FY04 for assistance to support state staff and one parent representative traveling to AMCHP and for state staff traveling to MCHB mandatory meetings. The Commission will also request funding to support a consultation from staff of the Healthy and Ready to Work National Center for the leadership team that is designing the Building Linkages to Transition (BLT) project.

The Commission requests technical assistance during FY 05 from the National Center for Cultural Competency to provide training and assistance during the implementation of the Center's cultural competency self-assessment questionnaire. Following completion of the survey, the state and district offices will develop a plan that identifies 2-3 strategies for improving cultural and linguistic competency.

V. BUDGET NARRATIVE

A. EXPENDITURES

Budget projections for this section are completed before the state fiscal year actually closes. Budgets for various activities should be considered "point-in-time" estimates however, staff completing this portion of the Title V provide as accurate information as is possible at that time.

Actual expenditures may also be different then budget because of carryover and the varience of grant years. The state fiscal year begins on July 1st and ends June 30th. The federal grant year (Title V) begins October 1st and ends September 30th. Many department grants have yet other timeframes.

Generally speaking, budgeted and actual expended dollars have been relatively consistant within a given year. Any notes to explain variences have been attached to the financial form which they address.

For this reason, questions regarding specific financial activites should be relayed to the the Department for Public Health, Division for Resource Managment; the Division responsible for financial reporting.

B. BUDGET

Both the Division of Adult and Child Health Improvement and the Commission for Children with Special Health Care Needs will discuss FY06 budget within the section.

Division of Adult and Child Health Improvement, Dept. for Public Health

The vast majority of Title V Block Grant funding allocated by the Division of Adult and Child Health Improvement is allocated to local health departments to support community programs that work toward attaining MCH performance and outcome measures.

In addition to our MCH Title V funding, revenue from several major sources including KIDS NOW Early Childhood Initiative, KCHIP and Bioterrorism supports local health departments.

Based upon the current estimated block grant allocations to Kentucky in FY06, (total of $ 11,890984) 34.9% or $ 4,149,953 will be contracted through a memorandum of agreement with the Commission for Children with Special Health Care Needs and the remainder of $ 7,741,031 will remain with the Division of Adult and Child Health Improvement.

For FY 06, the majority of this funding (93% or $7,234,570) will be re-allocated through a block grant process to local health departments. Local health departments have the ability to select particular cost centers in which to use this funding. Additionally, they may use it for clinical (personal health) or community (population-based) services.

Clinical service include well-child, maternity and prenatal care, family planning, oral health and nutrition services. Approximately 90% of Title V funding is used to cover local health department clinical services.

Community Services implemented by local health departments include prenatal classes, oral health classes, physical activity campaigns in schools, teen pregnancy prevention programs, injury prevention activities and smoking cessation campaigns; just to name a few. Approximately 10% of Title V funding is used to cover community services.

Special emphasis has been placed upon physical activity and nutrition services for youth. The combined use of all of the Preventive Services Block Grant and a portion of the Title V MCH Block grant is allocated solely to underwrite activities addressing the issue of inappropriate weight for height

in Kentucky in children. As this performance measure is a primary health concern Kentucky's population, a combined use of these funds supports the intent of the block grant process; funding flexibility to address unique needs of states and communities.

In FY 05 funding to support prenatal care was designated for each county and health district; particularly for the uninsured and disparate populations. Program staff estimated that the costs of an uninsured birth are approximately $ 2,000 each. Hence, this sum was used to calculate allocations for Kentucky counties based upon historic needs.

Below is a listing of how Kentucky's local health departments are using Title V funding during FY05. This is a projection based on program plans submitted by the local health departments, reviewed and approved by program staff.

(CC 712)Dental Clinical Services $ 4,316 (<1%)
(CC 800)Pediatric Well-Child $ 2,367,955 (31%)
(CC 802)Family Planning $ 1,259,505 (16.5%)
(CC 803)Maternity $ 1,338,835 (17.6%)
(CC 805)Nutrition $ 1,627,115 (21.4%)
(CC 852)Resource Persons $ 1,334 (<1%)
(CC 818)Community Activities $ 867,064 (11.4%)
(CC 857)Physical Activity $ 152,867 (2%)

Total .....$ 7,618,991

Local health department allocations are based on a formula that takes into account population and need on a county-by-county basis. Funds are provided for clinical and community health and while certain programs are required (such as family planning, prenatal, child preventative, adult personal health and medical nutrition therapy), allocations for individuals programs may vary depending upon community need as determined by a local needs assessment process. Throughout this process, MCH Title V funds must be used to meet MCH performance measures and applicable 2010 health objectives. The Title V Administrator works with the budget review team who read each local health department plan and verify the proper use of MCH funding as well as the effectiveness of planned activities.

The Commission for Children with Special Health Care Needs receives 34.9% of the Title V Allocation which, in FY06, will amount to $ 4,149,953.

Additionally, capacity building costs for ACHI underwritten with Title V Funding include portions of two program contracts (Maternal Mortality Review and Public Health Training) with the University of Louisville. Funding has also been allocated in FY 06 to continue to support the Mental Health/Mental Retardation Suicide Prevention personnel($ 30,000). A new project is the Infant Mortality Project in Louisville Metro ($67,200).

Finally, some infrastructure costs for the Department for Public Health are underwritten by Kentucky's Title V Block Grant. This included a portion of the cost of Kentucky's local health department billing and services reporting system, Patient Service Record System (PSRS).

****

Commission for Children with Special Health Care Needs

The Commission anticipates the FY05 budget to include state and agency funds in excess of the 1989 maintenance of effort level. State and agency funding is expected to remain above the 1989 maintenance of effort level of $8,170,428 for the foreseeable future.

In addition to MCH Title V Block grant dollars, the Commission's primary source of funding are State

dollars (mix of state general funds and Tobacco Settlement funds) and Agency funds. The agency revenues are receipts from third party billings for direct patient care and care coordination. The Commissions' budget for FY05 is projected as follows: State General funds $6,205,000, Tobacco Settlement Funds $555,000, and Agency Funds $4,890,100. Other Federal sources of funding in the FY05 budget include CDC grant/University of North Carolina ($66,000); MCHB/Wake Forest University ($40,000); Sound Start (EHDI) Grant $126,000.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.